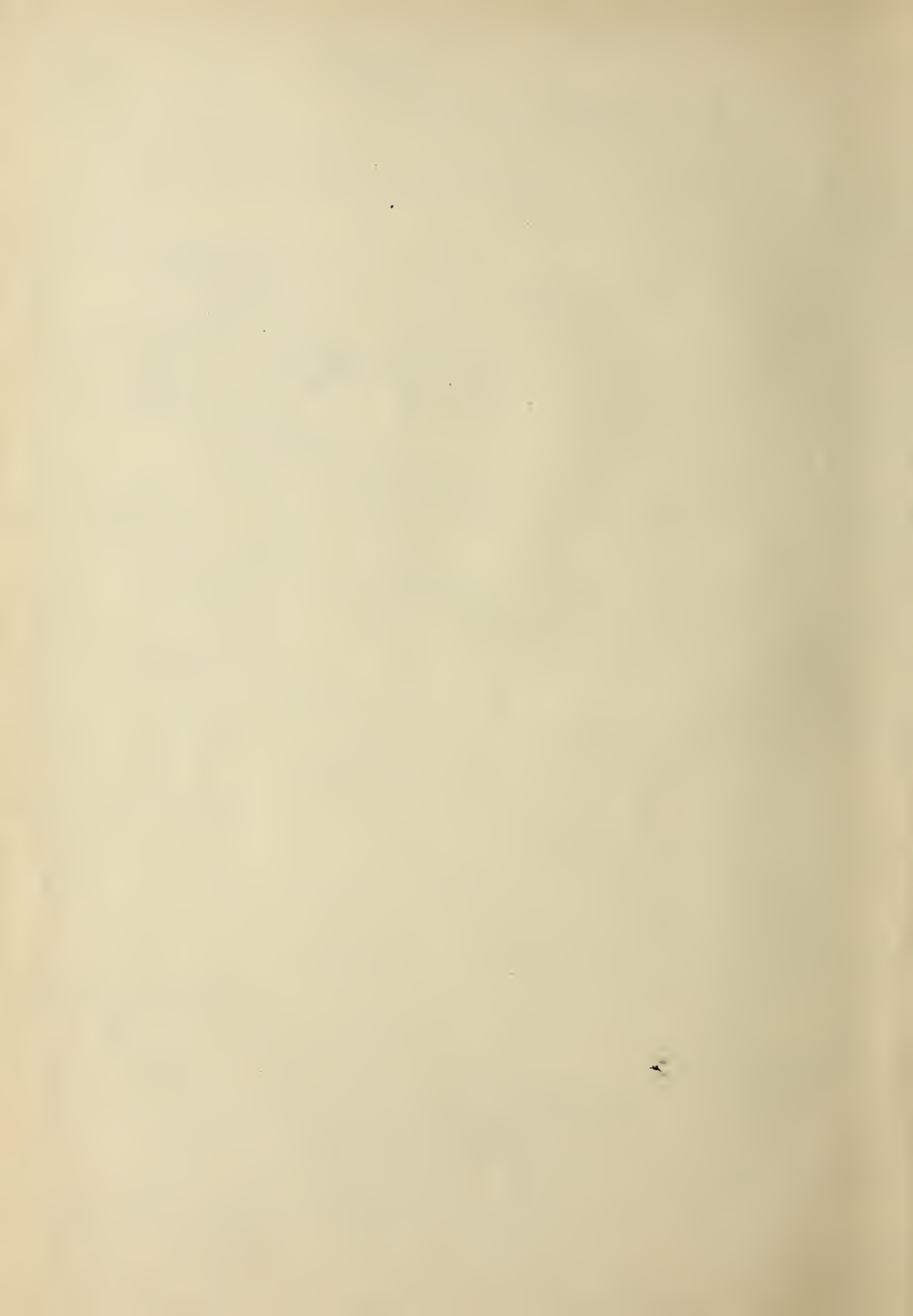
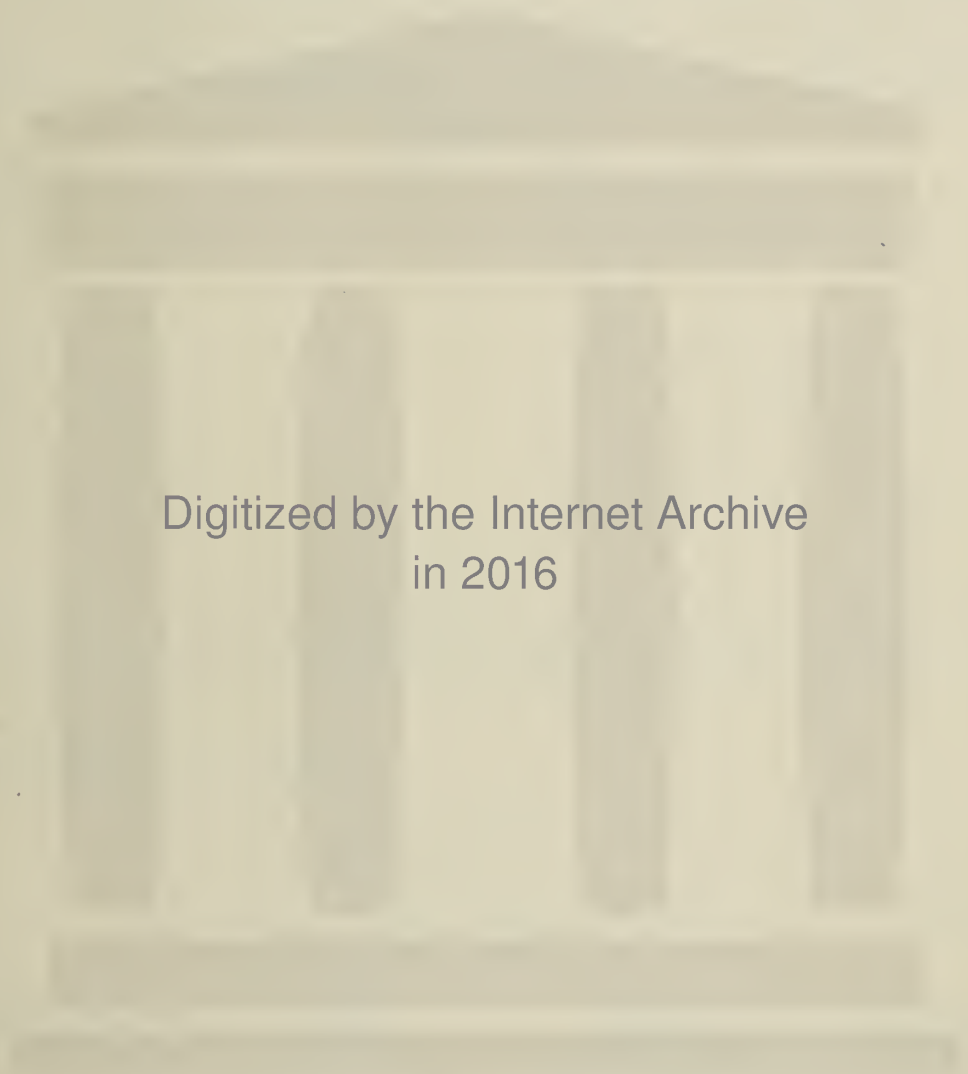


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THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

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ORANGE, N. J., JANUARY, 1934

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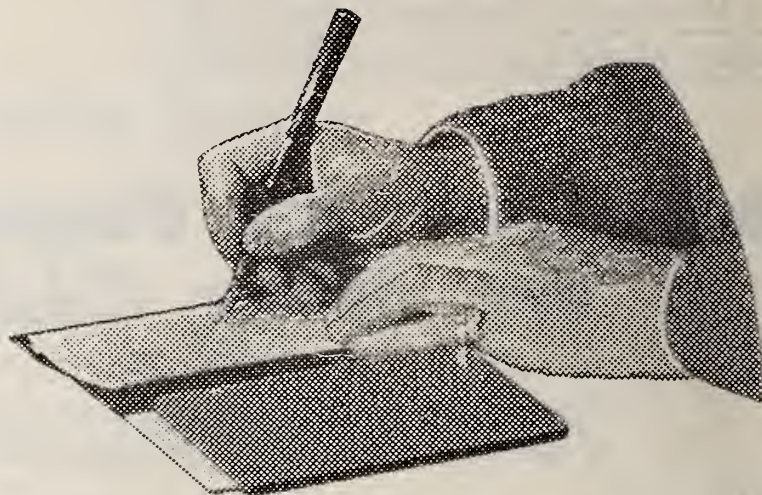
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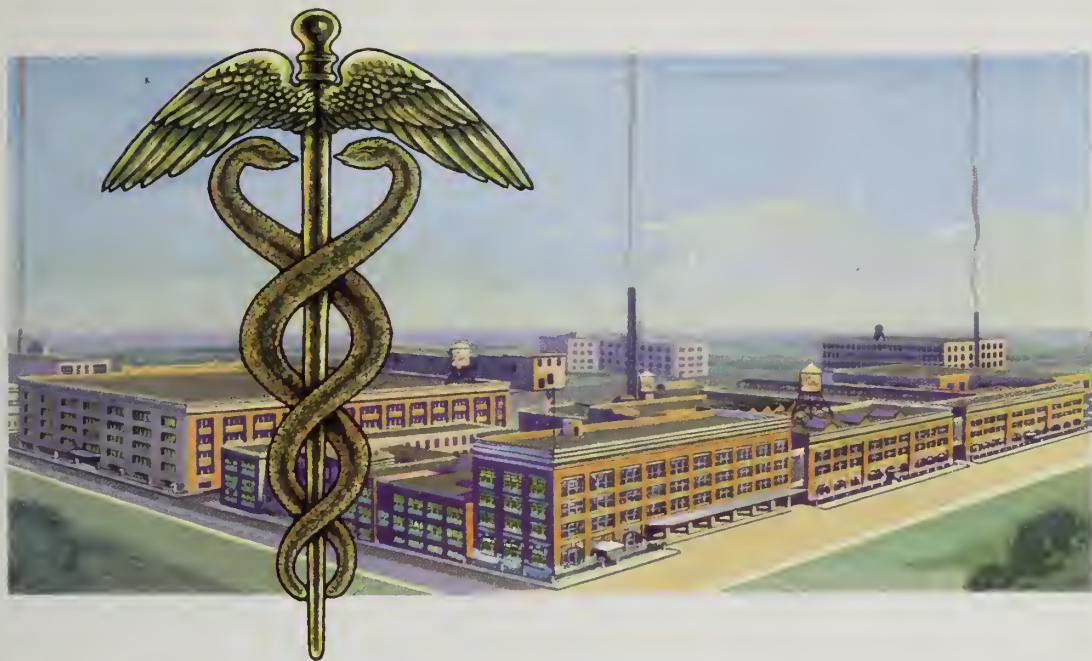
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(Newark Evening News, November 21)

Praise for the Binet classes of the Newark school system was expressed by Dr. Edgar A. Doll, Director of the Research Department of the Vineland Training School, at a meeting of the Binet Teachers' Association of Newark at Wickliffe Street School.

Teaching of normal children has improved as an outcome of methods used in handling the subnormal, Dr. Doll said. Alluding to the type of instruction which teaches the subject and not the child, he declared the troublesome pupil showed common-sense in "not taking the pills doled out to him".

"We cannot cure feeble-mindedness but we can cure some of its manifestations," Dr. Doll said of results obtained from special classes.

The speaker was introduced by Dr. Meta L. Anderson, Director of Binet classes in this city. Miss Harriet N. Mulford, President of the association, presided.

Tea was served with Miss Anna L. Gildea, head teacher of Wickliffe Street School, as hostess and Miss Grace R. Lewis and Miss Ruth V. Wells presiding at the tea table.

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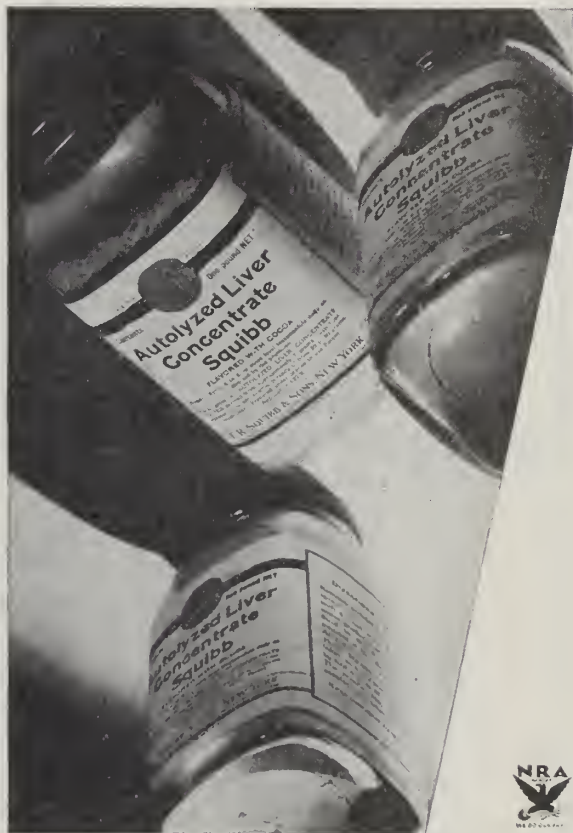
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VOL. XXXI., No. 1

ORANGE, N. J., JANUARY, 1934

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EDITORIALS

Cause for Reflection

As the new year begins, it is well for the physicians of the state and nation to ponder over present economic changes.

The Committee on the Costs of Medical Care, a year ago, presented a majority report which, in essence, favored state health insurance. While this report suggested that such a system should be voluntary in type, nevertheless experience shows that eventually it changes to the compulsory form.

The minority report of this Committee, urged by a group of its members most of whom were physicians, protested against these recommendations. They urged that united attempts be made to restore the general practitioner to the central place in medical practice.

In the year that has elapsed since that Committee's findings were published, much has happened in the general and economic history of our nation. Since the federal administration took the reins last March, projects have been put into force which are almost revolutionary in character.

How have these plans affected the medical profession? Many physicians are voluntarily engaged part of their time on medical work for the Emergency Relief Administration. They are giving medical care to unemployed

citizens on government rolls for home relief and are compensated for their work from municipal, state and federal funds. Millions of people employed on projects sponsored by the Civil Works Administration are covered by Federal Workmen's Compensation laws. The physicians who look after these accident cases receive pay from the national government.

Whither are we going? Is compulsory health insurance a natural sequence? At least, the groundwork is laid for its easy development. After the emergency is over, unless the medical profession is awake to the possibilities in the situation, the well-organized advocates of state medicine are likely to urge this type of medical service for the nation.

Some of our present methods of medical care very likely will be modified in the future—perhaps in the near future. Are our national leaders in the medical profession planning constructive measures to meet situations that may arise? Mere opposition to proposed plans is not sufficient.

A national policy and a national program are necessary. Forty-eight plans from as many states will not do. We must be prepared for concerted action when the time comes!

FREDERIC J. QUIGLEY, M.D., President,
The Medical Society of New Jersey.

The Journal

Most organized efforts, at certain periods in their existence, pause to review the objectives toward which they are striving. This applies equally well to a magazine or other publication.

AS THE JOURNAL begins the new volume for 1934 with this issue, it seems a good time to consider the purposes of our own periodical.

Journals of a medical character are numerous and varied. Some are dedicated to the consideration of scientific subjects; others confine their attention to questions of research. Again, these scientific or research matters may concern special fields of medical endeavor; hence the publications devoted entirely to certain specialties. Other magazines are of particular interest to hospital administrators, public health workers and the like.

THE JOURNAL of The Medical Society of New Jersey, like all publications which represent a State or a County medical society, has a specific purpose. The fundamental reason for the existence of such a periodical is service to the members of its organization. Each member upon receiving his copy expects, and has a right to find therein, articles and items which concern his daily life as a practitioner of medicine.

The life of the average physician is a busy one. In a day's work his thoughts and actions are concerned largely with clinical problems. In the pioneer period of American Medicine, clinical work was his principal, even exclusive, task. Fortunate indeed would be the lot of the present-day doctor if he could give entire attention to medical and scientific subjects. But our modern, complex social organization requires the physician to contend with many problems non-scientific in character but, nevertheless, intimately related to the practice of medicine.

The increase in the number of malpractice suits against physicians is alarming. The abuse of hospital and dispensary service, particularly in the larger communities, raises grave questions. Health departments and civic health agencies in many instances have invaded the field of medical practice to an unwarranted degree. Over-enthusiastic social reformers have plans to socialize the practice

of medicine. The medical profession is beset on all sides with these and similar problems.

Furthermore, the doctor must be kept informed of changes and trends within the practice of medicine itself. Society is demanding increased attention to the subject of health conservation. The physician must be prepared to take his rightful place as the family health adviser. The opportunities, obligations and responsibilities of the physician to community medical and health activities, need emphasis.

Little wonder that the doctor at times becomes bewildered when called upon to face such matters, while, at the same time, he endeavors to fulfil the requirements of modern medical practice. In the final analysis each physician must find the solution to his own needs and problems, but it does help to hear or read how his fellow-practitioners are meeting similar demands and difficulties.

A State medical journal should be one of the media through which the physician can establish contact with, or derive inspiration from, his colleagues. He may receive encouragement by reading what they are doing as individuals or in groups such as county societies. Since a great part of the physician's attention is taken up with clinical medicine, much of the subject matter presented should be of this character. At the same time items of professional interest coming from other parts of the state and from sister states should give to each member a broader outlook upon matters of a medical nature.

It is of interest, also, to learn what is being done by the State Health Department, the School Health Department and the many voluntary health agencies engaged in health work. Their activities have a direct bearing on the field of private practice.

Again, economic and collateral subjects, vital to every physician, should receive consideration commensurate with their importance. The economic problems which affect each physician and the medical profession as a whole, have developed with increasing force during recent years. Our difficulties have been accentuated in the period of depression through which we are passing.

As a State Society, we are fortunate in having leaders alive to this situation. Policies and

programs have been evolved by the present administrative officers and committees which should aid in meeting some of the economic questions of our Society members.

The Committee on Publication is fully aware of these policies and programs. Under the direction of this committee, considerable space in these columns during the next few months will be given to editorials, articles and other material having a direct bearing on these economic matters. Their great importance to each member of the Society warrants ample consideration.

The Editor will endeavor to present the various groups of subject matter in proper balance. He will be glad to receive suggestions and comments from members at any time, with respect to material for publication or other matters connected with *THE JOURNAL*.

The Executive Secretary

The previous editorial has commented on the objectives of *THE JOURNAL*; it is quite appropriate, therefore, to discuss the duties of the Executive Secretary. On the first of October of last year, a new policy for our State Society went into effect. The editorial and the field work of the organization, heretofore delegated to one individual, became separated into two positions. The Executive Secretary began his work with the Society in October; the Editor, in November.

One of the functions of the Executive Secretary is to act as a liaison between the administrative officials of the State Society and its component county societies. Policies and programs developed by the executives at the top do not trickle down to the component groups of their own accord. The Welfare Committee of the State Society, one of the most important of its committees, has a very extensive program outlined. If carried out, this program will have a far-reaching effect upon the members in matters of an economic character. The officers and the committee members are giving a great amount of time and effort at great personal sacrifice to put these plans into effect.

It is at this point that the Executive Secretary is needed. Results require the use of sus-

tained action. Action calls for time and energy. Volunteer efforts even though of the highest quality, fail quite often because the volunteers are not able to give the time necessary to carry projects to a successful conclusion. Therefore the need for individuals whose thought, time and energy can be concentrated upon the matters in hand. To secure results, state and county medical societies require machinery to carry on steadily and persistently. The Executive Secretary is an important part of this machinery.

Our State organization comprises twenty-one county societies. The environment of the physicians practicing in these areas varies from the strictly urban to commuting zones, towns of different sizes and rural districts. The problems common to all physicians, plus the needs peculiar to the different surroundings under which they labor—all of these become the problems of our State Society.

The Executive Secretary is required to keep well informed as to the work being done by each county society. He must establish close contact with the officers and committees, and in a general way at least, know the members in each county. Constant study of these county organizations is necessary in order that recommendations or requirements of a state-wide character can be applied intelligently and wisely. In short, a cohesive program must be evolved, applicable to the needs of the entire state.

An instance of how the Executive Secretary comes into action is in the development of the Emergency Medical Relief program. The co-ordination that has been effected between the State Relief Administration and the State Society, for the purpose of providing medical relief in the present economic emergency, is well known to our members. After tireless effort on the part of the leaders of our Society, a practical plan of this type of medical relief has been developed. Our President and his colleagues have explained the plan at county society and special meetings. *THE JOURNAL* has given considerable space to articles on the subject, and explanatory pamphlets have been broadcast to county societies. Nevertheless, in the execution of the plan, satisfactory progress in some parts of the State is lacking. Many

factors cause such delays, among which are: lack of understanding or misinterpretation of certain provisions; or, perhaps, it is the hesitancy incidental to cautious approach in new fields of activity.

The Executive Secretary has been visiting county societies during the past few weeks. These visits give him opportunity to see in actual operation the various ways and means which each county has developed to meet local needs and conditions. Quite often, peculiar situations arise which call for unusual methods in solving the problems involved. With a fund of information gathered on such visits, the Executive Secretary is in a position to offer aid upon request.

Again, the Executive Secretary is prepared to explain the broad outlines of the programs sponsored by the State Society. These explanations should guide the county units in adjustments of the local program necessary to conform to the general state-wide policy.

In effect, the Executive Secretary acts as a medium of exchange of ideas and experiences among the county societies. He becomes the intermediary through whom State Society planning is explained to the county societies. This assures uniformity and practicability in the application of the broad principles of the program. Thus coördinated effort becomes established.

It is the function of the Executive Secretary to study similar programs and experiences in other states and in other parts of the country. These studies may offer suggestions which can be tested experimentally at first. If proven successful, they can be carried out later in our own state organization and in its component county units.

Another important task of the Executive Secretary is the close observation and follow-up of proposed legislation which may affect the medical profession. This includes measures which the State Society favors and wishes to become law. Such proposals may originate within the Society; or they may be developed by other agencies directly or indirectly interested in medical or public health matters. On the other hand, it is necessary to watch carefully for legislative measures which, if passed,

would be inimical to the medical profession. Mere mention of the activities of certain cults, anti-vivisection propaganda and unfair compensation laws, indicates the type of legislation which may be pressed for passage by its proponents.

The Executive Secretary must scrutinize these various proposals and measures from their incipency, on through the various formative stages to their final submission to the committees and main body of the State Legislature for action. As Secretary of the Subcommittee on Legislation of the Welfare Committee, he keeps its members informed of the status of such proposed legislation.

The Executive Secretary serves also as the Secretary of the Welfare Committee and of the Public Health Committee of our Society. When District Council meetings or conferences of several of the District Councilors are held, the Executive Secretary is present and may be asked to assist in the preparation and development of proposed projects.

Space does not permit the enumeration of the many committees which function under our State Society. Refresh your memories if you wish by reading them as they appear on later pages of this issue. The number of these committees and the varied subjects covered by them are astonishing. Those of our members who give freely of their time and counsel serving on these committees are legion. Much of the data and information upon which these committees base their conclusions and recommendations must be prepared by the Executive Secretary.

The annual convention and other gatherings require a considerable amount of preparation. Here again the Executive Secretary is called upon to take over such details. Furthermore, there are certain duties, clerical and otherwise, in the administration of a well-knit, active organization, which must be supervised and carried out.

The Executive Secretary has no small job to perform. His duties may be summed up thus: Working under the direction of the President, to carry forward the policies and the program of the Society.

Amebic Dysentery

Amebic Dysentery has always been considered a tropical or semi-tropical disease. It is somewhat disconcerting, therefore, to discover rather suddenly that the disease prevails over a large part of the United States, both North and South.

In our own State of New Jersey, since attention has been directed to the presence of this form of gastro-intestinal disturbance, the efforts of the State Department of Health have uncovered several cases, some of which have been fatal. On another page of this issue, will be found an article by Dr. J. Lynn Mahaffey, Director, State Department of Health, in which the present situation in this State is described. He points out some of the laboratory procedures which the Department offers to physicians who desire these diagnostic aids. The control of the carriers of the *Endameba histolytica* is outlined briefly.

Probably most of our members have read the editorials and special articles on this subject, which appeared in the November numbers of The Journal of the American Medical Association. In these and other articles which have been published since the present outbreak has been recognized, the symptomatology, differential diagnosis and treatment are discussed. There seems to be a decided difference of opinion as to the value of certain medications in the treatment of the condition, as shown by several letters which appear in these publications.

Unfortunately, the Chicago cases developed at a time when many visitors were in that city to attend the Exposition. Upon return to their home towns, the infected persons carried the amebae with them; hence the spread of the disease to many States.

So far as New Jersey is concerned, the first step in the control of amebic dysentery is to realize that it does exist in our state. With the medical profession on the alert for indications of its presence, cases heretofore not recognized should be uncovered.

From the community standpoint, it is important that physicians observe the rules and regulations which are in effect to control infectious diseases. These include the reporting

of cases and the many essential control measures. It is in this way that state and municipal health authorities are able to follow up the cases in an attempt to eradicate the parasite. Complete elimination of the disease may be extremely difficult, due to the persistence of the organism in the carrier. The tendency to recurrence of the disease is said to be quite marked, though some physicians interested in tropical diseases claim that the so-called recurrences are really reinfections.

Public Health Committee Projects

The Editor has asked me as your Executive Secretary to make comments in each monthly issue of The Journal on State Society projects or other matters which concern our members.

The program of the Public Health Committee of the State Society is a very important one. It may therefore be of interest to read the bulletin that recently was sent from headquarters to the member of the Public Health Committee in each component County Medical Society.

* * *

PUBLIC HEALTH COMMITTEE PROJECTS THEIR DEVELOPMENT

A survey of the Public Health Committee projects in the component County Societies of New Jersey is very encouraging. While there is not yet a *wide-spread* development of plans and activity, there are in certain counties very definite evidences of study and analysis of the report of the Public Health Committee of the State Society. Some exceptionally constructive suggestions have been offered by County Society committee members to the State Committee in a most kindly and helpful spirit. These suggestions contribute materially toward improving the State public health program and to an understanding of the variety of problems met.

The County Public Health Committee's suggestions and criticisms relative to the State Public Health Committee program are invited and will be appreciated.

The State Society's Public Health Committee claims for its members no inherently su-

perior cerebral ability. The President has, however, appointed on this Committee, members of wide experience in public health activities, and who have had the privilege of observing and sharing in work of state-wide and national importance. An exchange of viewpoints and experiences with experienced workers is always stimulating and helpful to all concerned.

After the recommendations contained in the State program have been analyzed in relation to the established needs and resources in each county, and local plans and the scope to be covered have been determined, the County Medical Society is requested to send a copy of their plans and schedules to the Chairman (or Secretary) of the State Public Health Committee.

OUTSTANDING EXAMPLES OF COUNTY AND STATE SOCIETY CO-OPERATION

One of the most thorough analyses made so far of the State Society's tentative public health program is that made by the Gloucester County Public Health Committee. Each County Society's Public Health committee members should make such an analysis and make constructive criticisms and suggestions to the State Society and for their own County Society public health development. County Societies have already developed quite extensive programs—especially Bergen County.

THE TIME IS RIPE FOR ORGANIZED EFFORT

If the medical profession is to regain leadership in the health field, its leaders must clearly define the health needs of the *present day*; plan a program to adequately meet these needs; organize to work out together and in coöperation with other allied workers, these plans in a practical and economic way so as to produce convincing results. This is a time for calm and straight thinking; for long hard hours of work. Shoulder to shoulder, of *our own free will* we must work out a plan and make it work successfully. Victory is on the side of *organized effort* in these times. Shall we organize, or shall we wait to be organized for *health service* in the community?

We shall be leaders only as a result of what we do—not because we ARE physicians!

CO-OPERATION PLUS EXPERIMENTATION

Bergen County, Atlantic County, Essex County and others are organized and ready to begin on the "Diphtheria Project" which is to be the chief concern of the Public Health Committee for 1934. Other local health projects will, no doubt, be added in these and other counties during the year. The single project of diphtheria immunization will be carried on in *every County*. Every County Medical Society must *coöperate* in diphtheria immunization if the State project is to achieve the success we predict and hope for—particularly in the early years of child life.

INFANTS AND TODDLERS PREFERRED

The Public Health Committee should develop leaders in Child Health programs in the community. The practice of prevention really begins before birth. It includes heredity—but we cannot do much about that except in selected cases. The physician *can* begin soon after the birth of the child to protect the infant against diphtheria. In the years before children go to school, the physician can immunize any child still susceptible to diphtheria. He can watch the toddler's growth and development and correct significant physical defects. He can advise parents as to their child's habits and nutrition. Care of the infant and the preschool child in the home is the objective toward which the physician helps and guides the parents.

PARENTAL EDUCATION

Parental education should be made more practical. Theoretical and pseudo-scientific parental education is dangerous. Young parents, especially, need advice because they lack experience. The County Medical Society members can do much to stabilize this worthy endeavor. Advice must be based upon experience and understanding. Such advice can best be given by an experienced physician. His training in both prevention and cure has been practical as well as scientific. Physicians must impress upon parents the fact that the *best* advice for their child is that which is adapted to *his* needs and capacities.

LEROY A. WILKES, M.D.,

Executive Secretary.

ORIGINAL ARTICLES

INTELLIGENCE TESTS AND INTELLIGENCE TESTING

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Many physicians, skeptical of the value of intelligence tests, believe that intellectual keenness can be evaluated by personal contact or casual conversation. To a limited extent this is undoubtedly true. An experienced physician can estimate blood pressure or body temperature by feeling the pulse or touching the skin, yet he does not hesitate to use the sphygmomanometer or clinical thermometer when these are available. The psychometric test may be considered an instrument, like the blood pressure apparatus, designed to measure objectively a body function.

CRITICISMS OF INTELLIGENCE TESTS

Among the common unfavorable criticisms of intelligence tests are the charges that (1) it is unfair, in that success depends on quick rather than efficient thinking; (2) it is inaccurate, in that the better educated of two equally intelligent persons will receive the higher rating; (3) it is unsound, in that its results are often at variance with experience. It is in illustration of the last mentioned complaint that such situations as these are presented: a child with a high I. Q. failing of school promotion, a disagreeable, unadjusted person scoring a normal rating, a patient obviously insane, showing no abnormality when subjected to psychometric tests, or a charming, educated, successful person receiving a border-line diagnosis. But to cite these instances as evidences of the invalidity of the examination, is to show a misunderstanding of its function. Not measuring diligence, the test can not fully explain success or failure in school; nor does it make any pretense of evaluating social adjustability or emotional integrity, sanity or acquired knowledge. The psychometric test measures, and is intended to measure, one trait only—the efficiency with which we think.

An individual intelligence test puts no pre-

mium on speed. A group examination, on the other hand, is given at one time to an entire class; in this case the testing time is limited, and speed is a factor in the score. Unfortunately, it is with the latter form that the general physician is familiar. Seeing one of these administered, the observer erroneously concludes that time limit is an essential feature of intelligence testing. The individual test, such as the Binet-Simon, sets no time limit within which the subject must answer the questions or solve the problems.

Nor can it be said that the intelligence test by requiring an extensive fund of knowledge favors the educated person. For the most part, the information called for is acquired outside of school, and absorbed and retained according to the subject's intelligence. An examination of the Binet-Simon forms, for example, shows no questions on history or geography; the arithmetical operations demanded are few in number and of the sort one meets in daily life; the objects to be compared or distinguished are those found in the home or street environment of the ordinary child.

APTITUDE AND ACHIEVEMENT TESTS

Most of the questionnaires, so-called "psychological tests" and similar forms of examination submitted to school children and college applicants today, are not intended to be intelligence tests at all; they are aptitude or achievement tests. The latter is frankly an effort to determine how much the pupil has absorbed of one subject or another during his scholastic career. An aptitude test measures inclinations and special abilities; there are music aptitude tests, teaching ability tests, mechanical aptitude tests, etc. Many of the misconceptions on this subject, especially those entertained by the general public, are due to

the incorrect assumption that these special examinations are supposed to be intelligence tests.

THE BINET-SIMON TEST

The most widely used of the individual intelligence tests is the Binet-Simon scale. Since its introduction a quarter of a century ago (in 1911) it has been administered to millions of children all over the world. As modified by Dr. Terman, of California (called the "Stanford Revision"), it is considered the standard individual psychometric test for diagnostic and prognostic use in this country. The validity of any other scale is indicated by its correlation with the Binet.

The Age-Grade Method: The unique feature of the Binet-Simon test is the age-grade scale. This is a series of 90 problems arranged in order of difficulty; the easiest can be solved by a normal 3-year-old child; the most difficult only by a superior adult. These tests were so classified by empirical methods only. Binet did not start with the idea that a child of a certain age ought to be able to solve a certain problem; rather, he offered the problem to thousands of normal children of various ages and found the youngest group most of whose members could give a satisfactory answer. This was then considered one of the tests for that age. For example, a picture of a face with the nose missing was presented to normal children of 5, 6, and 7 years old. Few of the 5-year-olds could name the missing part; few of the 7-year-olds failed to do so. About three-fourths of the 6-year group gave the correct answer. This accordingly was considered a fair test of 6-year intelligence. Of course, no single test suffices to indicate an intellectual level. Each year is represented by at least 6 tests; and each test consists of several problems or questions. There are, thus, at least two dozen questions or problems for each year.

The type of test problem: A normal 3-year-old points to the conspicuous parts of his face when they are called for by name (nose, ears, etc.), recognizes common objects by name (key, pencil, watch, etc.) and enumerates the simple objects in a test picture. A 4-year-old can normally indicate which of two

lines (presented on a test card) is longer, can count 4 pennies, can match certain geometric forms, and comprehends and answers properly such questions as "what do you do when you are hungry?" At the age of 5 the child can recognize primary colors, can carry out certain simple commissions, and can tell which is the heavier of two specified weights. There are tests like these, largely independent of school training for each year up to 10. There is no 11-year group; tests are provided for the ages 12 and 14. Above the 14-year level the tests are of adult difficulty and their age classification has less chronologic meaning.

Method of Administration: Tests a year or two below the subject's actual age are first given; the examination then continues upward, year by year, until a level is reached at which none of the tests are passed. If the subject has failed any of the tests at the level first given, the form for a year earlier is administered, and so on down the scale until a level is reached at which all the problems are answered properly.

Calculation of Mental Age: At most levels there are 6 test series for each year; each test, therefore, has a value of $1/6$ of a year or 2 months; at some levels each series has a value of 3 or 4 months; administered in abbreviated form, the scale can be calculated by allowing proportionately increased credit for each test. By giving credit for the year represented by the level at which all tests are passed, and adding the proper number of months for each successful series, the mental age is calculated.

Mental age gives a vivid evaluation of the patient's intelligence. To say that an adult has the mind of a 9-year-old child is not only more accurate, but much more expressive than to say that he is a low-grade moron. Mental age should not be confused with I. Q. In the instance cited the patient had a mental age of 9, not an I. Q. of 9.

Determination of I. Q.: A normal child has a mental age equal to his actual age. The ratio between these, expressed as a percentage, is known as intelligence quotient, or I. Q. The normal 8-year-old, for example, with a mental age of 8, has an I. Q. of $8/8$, or 100 (%). If he is so brilliant as to have the mind of a

10-year-old, his I. Q. is $10/8$, or 125 (%); if he is very stupid and has a mental age of 6, his I. Q. is $6/8$, or 75 (%). Since both the mental and actual age are calculated to the nearest month, the I. Q. is seldom exactly 100. The normal range is between 90 and 110.

Interpretation of the I. Q.: An I. Q. below 70 in a properly administered individual intelligence test indicates mental deficiency. Idiots and imbeciles usually score an I. Q. below 50. I. Q.s between 70 and 80 are in the borderline group; between 80 and 90 are found dull but normal persons. Persons with an I. Q. between 110 and 120 may be considered definitely superior. A ratio of over 120 is found in less than 5% of the population and indicates a very superior degree of intelligence.

Reliability of the Binet-Simon test: The Binet scale has certain defects; modern methods in the training of infants are making the tests at the 3-year level too simple; the examination takes at least an hour to administer; it can be given to only one subject at a time. In spite of these defects, and in spite of the constant efforts of many competent psychologists to devise a superior scale, no better substitute has been devised. Goddard's opinion, expressed in 1912 (Vineland, N. J., Training School Bulletin), that "The Binet-Simon test is without doubt the most satisfactory and accurate method of determining a child's intelligence that we have, and is so far superior to everything else which has yet been proposed, that there is nothing else to be considered", is just as true today.

WHAT IS INTELLIGENCE?

Intelligence is the efficiency with which we think. It is the product of several forces and not an independent unit. It is not a single trait found in greater quantity in the genius and in meagre amount in the idiot; it is, rather, a complex of many qualities. The fact, that one person is more intelligent than another by no means indicates that the former will act more intelligently at a given time; for the superiority may be in factors not called for by the specific situation. The elements which, properly integrated, make up intelligence include memory, analytic skill, judgment, ability to make fine distinctions, speed of think-

ing, grasp on abstract concepts, and many others. A good psychometric scale includes many problems and questions, some of which test one of these functions, some another. The success of the examination depends on the validity of each test in evaluating the trait which it calls into play. It depends, also, on the similarity between the distribution of various types of problems in the test and the proportion of corresponding qualities in daily intellectual activity. Binet, himself, considered that his scale measured general intelligence rather than specific mental traits; yet a survey of the problems in his test will show that some of the problems tax certain functions and as definitely ignore others. As an illustration of the special traits required to solve some of the problems, consider the following examples:

(1) A picture of a Dutch kitchen is shown to the child; a wind-mill can be seen through the window. In the kitchen are a woman and a little girl, both in conventional Netherland costumes. The girl is crying, the mother is looking at her. A loaf of bread and some slices cut from it are on the table. A normal 3-year-old can enumerate the objects in the picture. Comprehension, to a simple degree, is required. Memory, judgment, and analytic skill are not necessary. But at the age of 7, the normal child can describe what he sees. He adds verbs to the enumeration of objects; not only does he see the girl, but he sees that she is crying; he assumes that the slices of bread were cut from the fractional loaf visible. Some judgment and analytic skill are necessary for the proper description of the picture at this intellectual level. At the age of 12, interpretation is expected. The subject not only sees the girl, not only sees that she is crying, but offers an explanation for her tears. A still greater degree of analysis is required at this level, as well as some ability to reason backwards from effects to causes.

(2) An average 9-year-old child can find words to rhyme—with "day", for example. But to most persons the word "day" first suggests "night". In correctly answering this problem, the child must first make and then reject this association; he must shut out all associations except sound; he must search his

vocabulary, silently comparing words, until he finds "play" or "say". Here is a problem which requires the formation of proper and the rejection of improper associations, as well as memory and vocabulary.

As an instance of bizarre, amusing, but altogether correct inductive reasoning, I recall the examination of a 12-year-old boy committed to the Newark City Home for larceny. One of the 12-year tests is the interpretation of fables. This is an excellent method of evaluating inductive reasoning skill, for it necessitates the derivation of a general principle from a concrete instance. The boy was told the story of the crow that stole some meat and perched on the limb of a tree to eat it. A fox, desiring the meat, began flattering the crow, complimenting it on its beauty of form, feather, and voice. Eventually the fox persuaded the bird to give him a sample of her beautiful singing; but in opening her mouth to do so, the meat fell toward the ground, into the jaws of the wily fox. Asked what lesson this story taught, the boy answered: "It teaches that when you steal something you should keep your mouth shut." This ingenious answer indicates definite ability in reaching general conclusions from specific situations. While the ethics may be deplorable, the logic is sound.

As a reverse instance—the inability to generalize from concrete circumstances—I remember a boy at the same institution who insisted he was innocent of the robbery for which he had been committed. He said that he had been arrested because he associated with dishonest boys, but that he, himself, was guiltless. In testing this boy, I gave him the fable of the farmer who set a trap to catch cranes which had been stealing his seed. He caught a stork who had not been stealing at all, but who had been flying around with the cranes. In spite of the stork's innocence the farmer shot the bird. This story was meaningless to the boy; he said it taught one to be kind to animals. He was unable to lift the interpretation out of the animal kingdom and could see no relationship between the fable and his own predicament.

Similar problems at the annual levels test one function or another. Viewing the scale

as a whole, one is impressed with the large number and rich variety of intellectual faculties brought under scrutiny.

GROUP TESTS

Because of the time required, it is obviously impossible to administer an individual test to each pupil in a large public school system. Moreover, since two-thirds of the pupils would score an I. Q. between 90 and 110, it is not necessary. In order to indicate gross abnormalities of intelligence, or general class averages, group tests are used. These are booklets given to the student, one test on each page. Unlike the Binet-Simon technic, the method requires a time limit for each series of tests. Such elements as nervousness, frivolousness, poor reading ability, poor vision, etc.—defects readily recognized and weighed when administering individual tests—necessarily lower the validity of the group scale. In spite of these sources of error, much valuable information can be obtained in a short time by the use of this type of examination. In a survey at the Newark City Home, made in 1932 by the author, 100 boys were tested in class by the Kuhlmann-Anderson group test, and re-examined individually by the Binet-Simon scale. The average I. Q. was 81 by group and 83 by individual test. In only 6 instances was there a deviation by more than 10 I. Q. points. Other examiners have reported similar correlations.

Most group tests call for the reading of printed directions and require an appreciable amount of school-acquired knowledge. In some tests, such as the Detroit, the Kuhlmann-Anderson and the Army Beta, figures, pictures, forms and pantomime are used to a large extent. The group test has a definite sphere of usefulness, but, of course, does not compare with the individual scale in validity.

THE TESTING OF ADULTS

The least satisfactory section of the Binet-Simon test is the upper end of the scale. Feeble-minded adults can be classified readily, but of the normal adult the examiner can merely say that the patient's intelligence is inferior, normal, or superior. Finer quantitative discriminations can not be made. No psychologist has yet devised a formula or test

for evaluating and differentiating the types and degrees of adult intelligence.

The I. Q. of an adult is calculated by dividing the mental age by $14\frac{1}{2}$. At one time it was thought that the normal person's intelligence failed to grow after the age of 16, that latter number being accordingly used as the denominator of the I. Q. fraction for any adult. Experience during the war with psychometric testing on a large scale has led to a downward revision of that figure. An adult with a mental age of 16, therefore, has an I. Q. of $16/14\frac{1}{2}$, or 110.

SUMMARY AND CONCLUSIONS

(1) The individual intelligence test, of the Binet-Simon type, is an instrument for evaluating the efficiency with which a child thinks.

(2) The test is of uncertain value in the examination of normal adults, but is a useful

method for classifying the feeble-minded of all ages.

(3) A group test, although less accurate than the individual type of examination, is of service in making rough classifications of a large group or in determining comparative class averages.

(4) No intelligence test measures sanity, scholastic diligence, social adjustability, or emotional stability. The psychometric test measures efficiency of thinking and nothing else.

(5) A psychometric test, like the clinical thermometer or the sphygmomanometer, is an instrument for the measurement of a body function. To estimate intelligence by personal contact or casual conversation is analogous to measuring temperature by stroking the skin or blood pressure by feeling the pulse.

THE AVOIDABLE FACTORS IN MATERNAL MORTALITY

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A critical analysis of a series of maternal deaths, that is, deaths of women dying of causes connected with pregnancy, parturition or the puerperium, will show that a certain percentage could be regarded as preventable. The proportion will vary according to the detail and accuracy of the case histories.

The prevention of these deaths rests upon two large elements: (a) the nature of the care given to the maternity patient, and (b) the time and manner of its reception by the patient. The care of such patients is given by physicians, midwives, nurses, and, impersonally, by hospitals. Of necessity, there will be many variations in the kind of care offered by this group. It may be good, bad, or inadequate. The patient may seek care early in her pregnancy, but ignorant of its quality, she may suffer therefrom; again, due to social or economic reasons, she may not ask for care until

late in pregnancy or when in labor. Her reaction to such care as is offered, may vary from a steadfast observance of proper directions to a flagrant disregard of all advice, with attendant consequences.

In an analysis of puerperal fatalities and maternal deaths, when an attempt is made to determine the preventability of the deaths, it is apparent that much depends upon the type of care given. If poor or indifferent in quality, the responsibility may be laid at the door of the medical attendant, midwife, or nurse. On the other hand, if it is found that adequate maternity care, when available, was not sought by the patient sufficiently early, or being properly given, was not accepted by the patient or the advice disregarded, then the responsibility must be laid at her door.

The proportion of preventable and non-preventable deaths varies in different series of case analyses. The rules governing the analysis may be dissimilar; one group may expect ideal practice, while another group may be

swayed in their decisions by a particular interest in some one phase of the problem. The accepted medical practice of the community under study, furnishes the best rules for judging omissions and deviations. The British Committee on Maternal Mortality and Morbidity in its final report considered 51% of maternal deaths to be preventable. Their case histories, sent in from all parts of England and Wales, were abridged forms. Using the same governing rules, Kerr and McLenahan reviewed the fully detailed histories of maternal deaths in the Royal Maternity Hospital in Glasgow, and decided that 70% of these deaths should have been prevented.

When one goes beyond the term "preventable", and seeks the reasons for using it in connection with a maternal death, certain factors stand out prominently. These primary avoidable factors, or basic errors, have been defined by the British Committee as follows:

(A) Omission or inadequacy of antenatal examination.

(B) Error of judgment in the management of the case.

(C) Lack of reasonable facilities.

(D) Negligence by the patient or her friends.

How do these factors operate in individual cases or conditions?

As an example of the first we may take the effect which good prenatal care has had in reducing the number of severe or convulsive toxemias of pregnancy. Consequently, in analyzing a death from eclampsia, there must be close scrutiny of the nature of the prenatal care. If facilities for obtaining good care existed but it was not sought, such an omission becomes the avoidable factor. If sufficient care was not given, as, for instance, the non-performance of blood pressure readings or urine examinations, the first factor is again present. In the first instance, the patient is primarily responsible; in the second instance, the physician.

If a physician omits pelvimetry and determination of cephalopelvic relationship, and his patient after a long, fruitless labor is sectioned and dies, possibly from sepsis, the primary avoidable factor is inadequacy of prenatal care. The original physician is responsible, not the

operator whose forced section is followed by a septic death.

If the warning sign of slight painless hemorrhage in placenta previa is disregarded by the attendant until action is necessitated by the profuse blood loss at the onset of labor, and a catastrophe ensues, the primary avoidable factor of inadequacy is present, with responsibility assigned to the physician. Particularly in cardiac cases does the avoidable factor, omission or inadequacy of prenatal examination, stand forth in the tragedies of such labor cases.

The second primary avoidable factor, error in judgment, is evident in cases of toxemia which have been allowed to progress to an overwhelming degree of severity. It is apparent in many operative deliveries by insufficiently trained men. It is evident in the handling of some hemorrhage cases, as in the omission of intrauterine packing and intravenous infusion or transfusion, either before or after delivery. In the curettement of septic abortions and multiple operations in extrauterine pregnancies, it is present.

The third primary avoidable factor, lack of reasonable facilities, does not so frequently concern the city physician as it may concern his rural colleague. But with a country so profusely supplied with hospitals as the United States, and with early recognition and prompt hospitalization of the abnormal case, such an avoidable factor will be found to affect but few.

The fourth primary avoidable factor, negligence by the patient or her friends, is found in many cases. This consists in disregard of advice in most instances. It prevents therapeutic abortion in vomiting of pregnancy at a time when the patient might be saved. It promotes toxemia by refusal to adhere to diets and hygiene. It accelerates toxemia in preventing hospitalization and induction of labor. It endangers cardiac and hemorrhage conditions in a similar manner, and is often operative in sepsis.

To what does a study of these factors lead us? Certainly, to a realization that education is the one influence that will help most in the problem of reducing maternal mortality. It must be realized that this education should

include both of the elements concerned, the patient and those who care for her in maternity. For the pregnant woman, her family and her friends there must be a sane and persistent campaign to bring to the laity a full and complete understanding of what constitutes adequate maternity care. They must know what is adequate maternity care to be able to appreciate it and to request it. This should render largely inoperative the first and fourth primary avoidable factors, omission or inadequacy of prenatal examination and negligence. If a woman knows why she is told to do certain things during pregnancy she will be more likely to do them. The same education will make the patient conscious of the need for reasonable facilities for her confinement. It will aid in hospitalizing the patient where advisable, and in other situations aid in more suitable and efficient preparation for home confinement. If the patient and her friends understand more fully the danger of warning symptoms and signals, negligence may be largely reduced as an avoidable factor.

Such an educational campaign may be carried out through various channels. The use of Motherhood classes and "patient with husband" meetings in prenatal clinics or centers, will permit much definite information of a positive character to be imparted directly. Newspaper articles of a suitable make-up on prenatal care, especially in foreign languages, radio talks on appropriate occasions, and addresses before all types of adult lay organizations will assist in disseminating informative material. Such programs must be built up step by step in accordance with the nature of the community. Diphtheria, typhoid and small-pox were not conquered by a one-year program of education on immunity, sanitation and vaccination. These diseases, as well as tuberculosis and cancer, have been subjected to a long, persistent and continuous barrage of education of the public as to their etiology, symptomatology, prophylaxis and prevention. The same effort should be made in regard to maternal mortality. No one can deny that some progress in reducing toxemic deaths has been attained through efficient prenatal care.

The education and re-education of the physician, midwife, nurse and hospital is a prob-

lem for the medical profession. This must begin with a revision of the present unsatisfactory teaching of obstetrics to the undergraduate. Obstetrics must have a number of teaching hours equal to those allotted for teaching medicine and surgery. There must be a greater number of supervised deliveries before graduation. The intern year must include a sufficient training in normal obstetrics. Conservatism must be stressed; not an effort made to reach the highest operative delivery incidence possible. Facilities must be provided for hospital appointments in large maternity centers for physicians who wish further training toward specialization. Teaching hospitals and centers must provide for short intensive courses for graduates. Re-education facilities must be planned for the man in practice; education must be taken to him. Hospital staffs must organize and conduct obstetric conferences at suitable intervals, at which morbidity and mortality, technic, methods and suitable educational cases should be discussed. Attendance should include all open or courtesy staff men. Specialization must be defined, provided for, and insisted upon as a criterion of staff appointment.

The midwife must be educated, licensed, periodically re-examined to determine her continued fitness, and be under close regulation.

The nurse must be educated in the essentials of obstetrics and in the principles of asepsis. For the obstetric assistant nurse, facilities must be provided for intensive graduate training.

Hospitals, in their lay organization and administration, must be educated to the need for suitable and separate provisions for different classes of maternity cases. There must be room for observation of the patient; separate areas for the toxemic, hemorrhagic, or cardiac patient as well as for abortion cases; and available facilities for the segregation of the septic patient. Coöperating pediatricists and internists should be included in the obstetric staff. The open hospital staff may be regulated as to type of work permitted according to demonstrated ability. Prenatal clinics should provide ample space and a sufficient number of assistants for the necessary social work.

When the pregnant woman, through these

suggested measures, appreciates, requests, and receives adequate maternity care, then, and then only, can we expect to avoid the primary causative factors and see a reduction in our maternal mortality rate.

Such an educational campaign merits the continued attention of your maternal welfare committee.

DISCUSSION

Dr. Robert A. Mackenzie (Asbury Park): This paper by Dr. Williams has been most instructive and stimulating. It is especially valuable to have pointed out again the danger of operative interference. Just a year ago the Maternal Welfare Commission, in a resolution introduced by Dr. Mount, urged upon all hospitals in this State the supervision of all abnormal obstetric practice. I understand that the Atlantic City Hospital, and I can definitely say that both of the hospitals in Monmouth County, have realized this need and have taken steps to bring major obstetric problems to the attention of men trained in operative work. These are necessary precautions which, tactfully enforced, should offend no one and benefit many.

In the consideration of mortality and also morbidity figures, however, it may not be appreciated that in many cases it is not the manner of delivery but the length of time in labor, particularly with membranes ruptured, which lowers the mother's resistance to infection and makes her susceptible to operative shock. The presence of even a mild toxemia or the existence of a physical defect other than pelvic may be important in the same sense. Careful estimation of the size of the pelvis and accurate diagnosis of presentation of the foetus are essential if one is to prevent or provide measures to support protracted labor.

A word may not be amiss here, relative to the need for proper preparation of obstetric patients for operative delivery. Who can deny that the strain of vigorous labor for 12 or 24 hours does not seriously deplete the glycogen store, tax the cardiac reserve, lessen nerve force, and make easier the process of bacterial invasion? Few of my patients take fluids well during labor and giving nourishment is completely unsatisfactory. It is a grave mistake to wait for rising pulse rate, acetoneuria and other signs of exhaustion and acidosis, before giving a refreshing clysis or a sustaining injection of 10% or even 25% glucose intravenously. Certainly such supporting measures are most valuable before an operative delivery, and subsequently also. Only last week I had occasion to see a patient *long in labor* who had just about all the trouble any one woman could have under the circumstances. I found a marked antero-posterior contraction of the pelvic inlet, the fetal head extensively molded but still above the inlet with occiput posterior. With membranes ruptured, the uterus was in a state of tonic contraction. In addition, this woman was preëclamptic—blood pressure 160/96, pulse 130. The baby was living, and delivery through the natural

passages being impossible, abdominal section by the extraperitoneal route seemed indicated. The patient was given immediately, therefore, 1000 cc. of 10% glucose intravenously and this treatment was repeated after operation. By these measures shock was minimized and the patient has done very well, in spite of a definitely infected uterus. The baby has made normal progress.

Dr. Cosgrove believes that his method of spinal anesthesia eliminates many of the hazards of inhalation anesthesia. Having used it in a few cases, I can understand something of his enthusiasm.

As Dr. Williams has mentioned, endogenous sources frequently have been proven to contribute many cases to our total puerperal infections. It is amazing to read the experimental work of Dr. Clara Guggenheim, bacteriologist of Hamburg, Germany, who stained the fingers of large numbers of women in the last month of pregnancy. Examination of these patients the following day showed that in 98% of the cases the dye actually had been carried to the cervix. Instances are frequently reported of sepsis in women who have been exposed to wound discharges; who, for instance, have cared for a child with a running ear. In April of this year, on my hospital service, a multipara was admitted with elevated temperature—delivered spontaneously without having been examined at all—and died of streptococcus hemolyticus bacteremia after a five weeks' battle. This woman had nursed several children with scarlet fever recently and had herself contracted the disease, being released from quarantine only one week before hospital admission. There can be no doubt that streptococci were present in this patient's vagina, indeed, had even begun to attack before the uterus had emptied itself by the normal processes of labor. The latest researches of Dr. Dochez of the Columbia Medical Center demonstrate that anaerobic types of streptococci found repeatedly in vaginal cultures and long considered innocuous, may change their characteristics upon occasion and assume virulent properties. This fills one with a sense of hopelessness in attacking this problem of endogenous infection. But we must remember that contact or droplet infection is of equal or greater etiologic importance, and here is our direct responsibility. Can we lean over a patient while making an examination without spreading bacteria from our own nose or mouth? Not unless we wear a suitable mask. And it is generally agreed that both nurses and physicians attending a woman in labor should be gowned and wear cap and mask. We are responsible for the increasing concentration of obstetric patients in institutions; it is our job to protect them from contact infection. Certainly, complete isolation-nursing technic for every febrile patient should be rigidly enforced. The question of visitors to maternity wards is not yet answered. Contamination may be transferred first to the bed or hands of the patient and then, as Dr. Guggenheim's work has shown, to the genital tract. At least we must advise against embraces, or even shaking hands with patients, for several days postpartum.

But the problem of prevention of infection is not of greater importance than the problem pre-

sented by persistence of poor obstetrics in most of our communities. The importance of competent obstetric diagnosis and management in reducing the incidence of infection has been considered. And many fatal cases, variously classified in the records as accidents in labor, eclampsia, hemorrhage, etc., might have been prevented or more successfully treated by proper handling. There may be excuses for poor judgment, but carelessness and neglect cannot be condoned. In the Monmouth Memorial Hospital in 1932, three out of nine maternal deaths were due directly to the barbarous treatment which preceded their admission. This is not an unusual experience as the director of any active hospital service will testify.

There has been no lack of propaganda for better obstetrics in this State; an abundance of sound teaching was offered in the Convention program last year; and in *The Journal* this year, through the extension courses arranged by Dr. Cosgrove and his educational committee in cooperation with Rutgers University. The trouble is, that the disinterested practitioners of medicine, the men who should be reached by this program, are successfully keeping their consciences locked in and new ideas barred out.

The White House Conference on Maternal Welfare, appreciating that education of the practicing physician has never met with much success, concentrated in their recommendations upon improvement in undergraduate obstetric teaching. Much progress has been made in this direction. In the field of postgraduate instruction, I believe, lies the great objective for Dr. Bingham's Maternal Welfare Commission. What Essex County has accomplished, as set down in the May issue of *The Journal*, should encourage everyone who has pride in New Jersey's record, and should sound a challenge to the other county maternal welfare committees as well. We shall work out something worth while in our meetings later this afternoon. At this time let me urge that the work go on; that the County Society meetings include at least one program a year of special obstetric nature and invite all the practitioners of the County, whether members or not; that the hospital staffs lend interest and cooperation to the work of their obstetric departments.

Dr. Albert B. Davis (Camden): Mr. President, Members of the Society: I have enjoyed very much hearing Dr. Williams, as we also do in the Obstetrical Society of Philadelphia; where everybody listens. He always has something worth while to say. I don't expect to add to what he has said on maternal mortality, but I will take our own cases for the last year, and try to draw some conclusions from them.

We had 8 maternal deaths in Cooper Hospital in Camden last year out of 1228 deliveries. Those 8 cases were, 3 eclampsias, 2 placenta previas, 2 abdominal pregnancies, and 1 encephalitis.

The eclampsias illustrate one point that Dr. Williams made; it is a situation which we all encounter. Two of the patients had had no prenatal care at all. They were girls illegitimately pregnant, trying to conceal the pregnancies from their own

families and who had not seen a physician either outside or in the hospital clinic. Apparently, to their own families, they were well until they went into convulsions. That illustrates the point of the cooperation of the woman herself.

In this country where there are so many of us free, white and of age, who do as we please, everyone is, to a certain extent, his or her own doctor. If these women will not seek the medical advice and the medical facilities that are all around them for a situation like that, the medical profession can't do much about it.

Of course, our education of the laity continues and I think we are making progress, in fact, a great deal of progress. But there are always certain ones who will not make use of medical facilities.

The only death we had in the ward so far this year, illustrates that very well. A girl 19 years old had had, previously, one baby in the ward. At that time, she didn't come to the hospital until she was eight months pregnant—just a month before her time. She had some hypertension and I sent her into the ward two weeks in advance; two weeks later we induced labor medically. She came through all right; had her baby without trouble. That same girl became pregnant again, did not come to the clinic or see a doctor or do anything about it, until she was sent in to the hospital after having had five convulsions. I said to her husband: "You had some responsibility in this. Why didn't you bring her in? I know she was told previously, because we tell everyone the necessity of prenatal care." He said, "I couldn't do anything against both her and her mother. Her mother had no use for hospitals and didn't want her to go." That shows how the older generation interferes once in a while.

The other eclampsia was postpartum; the patient came to the clinic all right. Her highest blood pressure was 140/80. She was in the clinic four days before admission, and then was admitted in labor and had her baby. She didn't seem sick. Her baby was born about eight o'clock in the morning and at two in the afternoon she had a convulsion. The patient didn't seem very bad; she was conscious afterward. About five o'clock, she had another convulsion, after which she didn't seem so sick either. Her blood sugar was 47. About seven o'clock she was found dead. Occasionally we run into cases of that sort, though not very often. Probably we always shall, to some extent. That girl did her part and, so far as we know, we did ours, though not fully.

There were two placenta previas. The more I see of them, the less I like them. Both of those patients were watched by their family physicians. One had bled occasionally for two months, though not severely; but the doctor should have known it was dangerous.

I have never forgotten a paper Dr. Ross MacPherson read before the Philadelphia Obstetrical Society some years ago. Dr. Williams was there and probably remembers it. The paper was on placenta previa, and emphasized emptying the uterus

as soon as the diagnosis was made. The diagnosis should be made on painless, causeless bleeding unless it can be otherwise excluded. The more we see of p'acenta previa, the more we wish that the general practitioner could be impressed with the importance of that advice.

The other patient had bled for about two weeks at different intervals. If those patients had been sent to the hospital when they first bled, after the first painless, causeless bleeding which occurred late in pregnancy, I think both would have been alive today. They both had transfusions. One we couldn't get into shape to do anything with, in spite of transfusion. The other had two transfusions; after the first transfusion, she was a little better. When she went into labor, I was able to do an easy extraction without further loss of blood. She was given a second transfusion at the same time. In spite of this treatment, the patient died of acute anemia. In these two cases, I don't know whether we could have done any more; they certainly should have been in the hospital earlier.

The abdominal pregnancies were interesting cases. I take a vacation from the service usually every summer and the first occurred during that time. The placenta was spread all over the right broad ligament, and following its premature separation an internal hemorrhage occurred before operation. I don't believe that the patient could have been saved.

The other patient was seen in the gynecologic ward. I saw her in consultation there, and probably should have made the diagnosis. Apparently, she had an infection along with pregnancy, got better, went home, and for two weeks was pretty well. She returned to the clinic not looking so well. I sent her into the obstetric ward and she got progressively worse. She had about a half dozen transfusions but we never could get her in shape for operation or do anything for her. She would come up a little bit after transfusion and then go down again. We found, at autopsy, that she had an infected abdominal pregnancy, a necrotic mass and sac, free in her abdomen, from which she was absorbing toxins. In that case, we really did not make the diagnosis until autopsy but I doubt if we could have done anything if the real condition had been recognized. However, that was a mortality that possibly might have been prevented.

The case of encephalitis was very interesting; it was, I think, a true encephalitis. We had a neurologist examine the patient. Her temperature was never over 99 2/5. She was talkative when she entered the hospital. The patient had a normal, spontaneous delivery and was in rather good shape physically, except she was talkative and inclined to increased reflexes. This continued for about four days, after which she went into a stuporous condition and died about four or five days later. I think this patient simply developed an accidental infection along with the pregnancy. So

far as could be discovered, her delivery had nothing to do with the infection. She came to the hospital in premature labor, probably because of the infection.

I suppose we should be glad that our mortality has not been due to sepsis or operation; this is so often the cause of maternal mortality. We had last year (and we may be open to some criticism for it) 64 cesarean sections at Cooper Hospital in which there was no mortality. I don't think we are "sectionists". As to the private cases I do not know whether they could be criticized, but I do know they were handled by competent men. There are only a limited number of doctors doing that kind of work there. The ward patients, I think, all required section. For my own part, I have more often than not been sorry I did not do a section. The year before last we had 45 sections without mortality; this year we have had 28 so far with no deaths. That makes about 137 sections altogether.

I know in 1930 or 1929 we had one spinal anesthesia death; lately I have not used spinal anesthesia so much in sections. We use ethylene and re-breathing apparatus (which cuts down the cost of our ethylene), and except for the relaxation of spinal anesthesia, in my opinion ethylene is quite as good. It is not so nice for the operator but it is good for the patient, and, generally, is safe. We have used it a great deal in cardiac patients and they have done very well.

The spinal anesthesia death was of respiratory cause, just at the beginning of operation.

The problem of maternal mortality is always interesting and I think we are making some headway in its solution. I know Dr. Bingham has done some very good work in New Jersey here, and has stimulated interest and progress in solving the difficulties. Furthermore the articles that have been put out by the Philadelphia County Society have done good work in our locality, as they have undoubtedly in Philadelphia. We have been active throughout the State of New Jersey. I believe we will accomplish something in lowering our mortality when we can educate the laity to make use of the medical profession and of the hospital and specialist as they should.

Dr. Arthur W. Bingham (East Orange): On behalf of the Maternal Welfare Committee of this Society, I wish to thank Dr. Williams for coming here today and giving us this excellent talk. We chose Dr. Williams because we knew that he, as Chairman of the Maternal Welfare Commission at Philadelphia, has had valuable experience and could give us something to take home with us.

We seem to have two problems: One, to educate the laity to go to the doctor; the other, to educate ourselves to take care of the patient after she comes to us. At times it seems very discouraging, but when it is realized how much needs to be done, we ought to go to it with renewed vigor.

AGRANULOCYTOSIS (PERNICIOUS LEUKOPENIA) INCLUDING REPORT AND HISTORY OF A PRIMARY CASE

Fatigue as an Etiologic Factor

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SYMPTOMATOLOGY AND NOSOLOGY

There is a symptom complex, which is a disease, *per se*, or else develops during the course of, or as a result of, disease already present.

The symptoms begin with a severe headache and a feeling of weakness. This is followed by fever and evidence of swelling and induration of the gums about the teeth, or the buccal or pharyngeal mucosa. Sometimes other parts of the gastro-intestinal tract are coated over in spots by a thin grayish-white membrane; or necrosis of some part of the gastro-intestinal tract develops with severe, almost agonizing, pain in the mucosal area involved. There is, usually, a high normal erythrocyte count and hemoglobin quantity; normal color index; and very low total white cell count with an extremely low percentage or entire absence of polymorphonuclear (neutrophils) leukocytes.

This symptom complex has been designated by many names. Agranulocytosis and agranulocytic angina are the terms most frequently used by authors of monographs to designate this malignant neutropenic or pernicious neutropenic symptom complex. Schilling, however, states that the term agranulocytosis has come into the literature only because of its brevity, and that the name was originally chosen for "neutrophils without granulations" of leukemias. The word "agranulocytosis" really means an increase of these atypical neutrophils. Schilling, who based his reasons on Tuerk's definition of this state as an atrophy of the neutrophilic system, prefers, and rightly so, the name "malignant neutropenia". However, it is apparent that, as usual, we will allow

usage to make an incorrect term appear correct, just as we now accept the ungrammatical term "it is me".

All authors I have read give W. Schultz credit for first describing in 1922 this symptom complex as "agranulocytosis". Schilling and Rothrock have shown that W. Tuerk in 1907 described it well, and Rothrock has shown, further, that P. K. Brown in 1902 in *American Medicine*, also described it. Both these authors, however, indifferently named this symptom complex. Clinical observations and laboratory investigations continue and are reported monthly; W. P. Murphy has written about it in a section in *Oxford Medicine System* dated July 1, 1930. The medical profession today is, or has the opportunity to be, well informed about malignant neutropenia and its variations.

ETIOLOGY

The neutropenic state occurs in the course of well-defined diseases, as: influenza, general infections, sepsis, focal infections, typhoid and paratyphoid (not septic); blood diseases such as splenic disease, leukemia and aplastic anemia, etc.; severe epidemic parotitis; tuberculosis; protozoal diseases, as malaria and trypanosomiasis (after the attack); dengue fever, Malta fever; acute poliomyelitis, chicken pox, sympathetic ophthalmia; chemical poisons, as arsephenamine and benzene; and, x-ray and radium irradiation. Neutropenia also exists in many people not showing discoverable lesions, but these patients are weak and easily fatigued. Roberts and Kracke in a study of 8000 patients demonstrated the necessity for knowing the patient's complete blood count.

Malignant neutropenia, whether acute or

chronic, is of unknown etiology. Piersol and Steinfield speak of granulopenia or granulocytopenia, and classify malignant neutropenia or agranulocytosis into (1) secondary, i. e., the symptom complex as it occurs in the course of other diseases, poisons or irradiations; and (2) primary, acute and chronic, when the etiology is unknown. The same authors, in this monograph, report experiments on rabbits by injections of common bacteria, and succeeded in producing only mild neutropenia of short duration. B. M. Fried and William Dameshek used *salmonella suispestifer* in rabbits because others found this micro-organism has a special affinity for the myelopoietic system and a special affinity for producing disease in animals. These authors claim that they produced conditions similar to acute agranulocytosis in human beings. Anaphylaxis has been suggested as a cause because an experimental anaphylactic state has resulted in a similar symptom complex.

Recently, Fitzhugh and Comroe have reported the analysis of 18 cases of agranulocytosis angina and placed the term "pernicious leukopenia" in parenthesis. Pernicious leukopenia seems the most appropriate name for this disease or symptom complex. The same authors, when discussing the etiology, draw a comparison between pernicious anemia and pernicious leukopenia. Pernicious anemia is well established as a disease entity *per se*, and responds promptly to a definite and well-established therapeutic test. Pernicious anemia symptom complex caused by parasites such as fish tapeworm, pregnancy toxemias, syphilis, sprue, gastro-intestinal carcinoma, partial chronic intestinal obstructions as in post-operative adhesions and the "lead pipe" colon, etc., does not respond to the liver or ventriculin therapeutic test, or only feebly responds. Fitzhugh and Comroe state, "Agranulocytic angina should be viewed as a disease entity which awaits the discovery of a specific therapy to stamp it with unmistakable validity." This same comparison may be read between the lines on pages 193 to 197 in Schilling's "The Blood Picture".

Fitzhugh and Krumbhaar have suggested a "maturation arrest" as a cause of the pathology in pernicious leukopenia. This suggests to

Doane certain analogies between this disease and pernicious anemia. But Fitzhugh and Comroe are the first ones, to my knowledge, to write of the striking therapy test comparison. An endocrine disturbance has also been advanced as an etiological factor; on what basis I do not know.

DESCRIPTION OF CASES

Some four years ago I showed at a Clinic Night of the Atlantic City Hospital a case of pernicious anemia in a bayman, 60 years old, the result of living on water, salt mackerel, salt pork, onions and occasionally milk. This 60-year-old bayman had plenty of fresh air exercise, sunlight and rest. Deficient diet with consequent avitaminosis as a factor in pernicious anemia has been well established.

Case 1. A woman with primary pernicious leukopenia (agranulocytic angina), treated by me in the private service of the Atlantic City Hospital, shows a somewhat opposite state of affairs, namely, a sufficient supply of a well-balanced diet all her life. For years she had had long hours of work, 14 hours a day for 7 days a week, indoors, which induced a state of mild exhaustion, later becoming severe exhaustion and, finally, a nearly fatal pernicious leukopenia. Even pleasure was exhaustion. For example, she and her husband would arise early and spend a few hours in the woods, hunting; following this they would go to their restaurant and work hard actually cooking, later supervising, buying, and tending at the cashier's desk.

There was in this patient no severe infections of past life, no venereal disease that had caused damage. She has been under my care since April 12, 1921, during which time her visits have been to the office for occasional pelvic pains which a few local treatments dispelled, and for common colds. March 28, 1923, a small ulcer on the mucosa over the hard palate was immediately cured by copper sulphate.

She was robust, rugged and not tired; 5 feet 8 inches in height; 190 pounds in weight. In 1926, visits became more frequent due to neuritis which appeared at intervals, and headaches began to appear, lasting a day. Joints occasionally pained. Mild upper respiratory

infections appeared, on and off. A short, mild attack of gastric distress with upper right abdominal tenderness developed but was relieved by duodenal drainage, alkaline medication and proper diet.

The tonsils were removed June 1, 1927, because of recurrent neuritis and mild joint pains and headaches. During this year, as pregnancy seemed finally impossible, she was very desirous of adopting a baby; this never happened, however. From June, 1927, when tonsils were removed, until January, 1928, she felt fine. Then the same symptoms of neuritis, headache, joint pains, occurring at different times, with, also, occasional ovarian pains and colds, started again. At this time, I first discovered changes in the cardiovascular system, the evidence of early sclerosis; by 1929, ectopic beats were present. Nervousness and insomnia were now, in 1929, appearing in a mild form. Still, she remained calm at her business, continuing 7 days a week and 12 hours a day at work. By 1930, headaches became severe and lasted as long as a month, their severity diminishing and increasing. Definite fatigue developed so that the patient, although having the appearance of robust health, complained of almost unbearable weakness, though neither relatives or friends believed she was actually ill. Cardiovascular sclerosis appeared to be increasing. May, 1932, she reported headaches more or less constant; pain in right arm, right leg, and left ovary for 1 month. I found a tired-looking woman with a dilated left pupil and a slightly drooping left eyelid and left face. August, 1932, she complained that her legs would not hold her up, but continued the 7-day, 12-hour schedule of work. February 17, 1933, she reported nervous "shakes" from 6 a. m. to noon. She had headaches every morning but still looked rather well; over-working but worrying, and a loss of 14 pounds in 6 weeks.

The foregoing summary covers her life since she was 26 years of age. She is now 33 years old. My diagnosis after several careful examinations still is chronic fatigue and chronic toxemia induced by overwork.

For 6 months preceding acute onset, psychic desire remained, but physical power was insufficient to obtain a complete orgasm. (This

history obtained from husband upon direct question.) She managed, however, to complete her long business day.

The actual onset of the attack of primary pernicious leukopenia was February 17, 1933. Her head began aching severely, perhaps more severely than ever. For headache alone, she sought relief. Her pulse, temperature and respiration rates were normal. Blood pressure, normal. Examination of the ears and nose, negative. The pharynx, fauces and oral mucosa, normal. The teeth were in the same condition that they had been for a long time, some gold caps and fillings but no gross signs of disease and no subjective symptoms. The patient was unrelieved, and on the following day fever of 103° developed and a thin grayish-white membrane appeared on the upper right central and right lateral gums. Forty-eight hours after onset, the gums of the upper right jaw were very slightly swollen and indurated and coated in small patches by a membrane; they were the seat of an agonizing pain out of all proportion to the local appearance. The headache was of the same severe type but could only be suspected by the expression of the eyes, and only known to exist by statement from the patient. The following morning complete blood count confirmed the diagnosis of pernicious leukopenia or agranulocytic angina. There was at no time any hemorrhagic diathesis or glandular involvement, but the spleen showed enlargement on percussion though not on palpation.

A smear was negative for Vincent's organism but contained a few fusiform bacilli and a few staphylococci. At the end of 72 hours after the appearance of headache, and 48 hours after appearance of fever and of membrane on the gums, a profound weakness set in. The tone of the voluntary muscles was affected, as shown by the facial muscles and decreased active movements in bed. On the fourth day (second hospital day) the color of the skin was the color of dirty ashes, a deathly gray. The muscles of the face sagged and the patient looked physically dead though mentally alert and in pain. She said she expected to die. Another 24 hours showed, I believe, the effect of treatment, and improvement was gradual but certain. The fever lasted a full 7

days, and came down like a lysis-pneumonia chart. The gums of the right upper jaw by the fourth day were very indurated and swollen, and remained so for a long time. This condition gradually improved until today, 3½ months after the acute attack, when slight swelling is still present. Weakness decreased but was present for 3 months. Headache remained for 2 months. At the end of 3 months the patient felt very well, and on May 3, 1933, had been doing all her own housework for 2 weeks.

Treatment consisted of a soft diet plus vegetable puree, ground meat and fruit juices; one haliver oil capsule and neobovinine, a teaspoonful in one glass of milk, t. i. d. One

ination on June 2, 1933, and reported apical pathology upper right canine, first premolar and first left premolar, and impacted upper right first molar. When these teeth are removed and if a culture obtained will grow, we will inject into a rabbit and report results.

Below are tables of blood counts and of treatments by injections, for quick comparison.

Case 2. The husband of *case 1*, 38 years old; leads same life as wife. Acute rheumatic fever in youth but completely recovered. Venereal history negative. He complains of weakness and fatigue of mild degree. Present physical examination negative. His complete blood count shows a granulopenia and

BLOOD COUNTS

1933	Eryth.	Leuk.	Hgb. %	C. I.	Polys.	Sm. L.	L. L.	Eos.	Bas.	Abnormal
2/20	4.4 mil	2000	84.4	0.9	0	98	2	0	0	0
2/22	4.4 mil	1050	84.4	0.9	0	99	1	0	0	0
2/25	4.4 mil	3300	81.1	0.9	20	75	1			4 Monocyte
2/28	4.09 mil	12,800	77.9	0.9	77	19				4 Metamyelocyte
3/3		12,450			71	27				2 Metamyelocyte
3/11	4.2 mil	6050	80	0.95	76	22	2			
5/3	4.3 mil	7000	93	1.0	60	37	3			

TEMPERATURE AND TREATMENT BY INJECTIONS

1933									
2/20	103.4° F.								
2/21	103.4° F.	0.45 gm. Neoarsphenamine intravenously							
2/22	102.6° F.	Pentnucleotide (S.K. & F.) 10 cc.	10 a. m.			5 p. m.		9 p. m.	
2/23	102.6° F.	Pentnucleotide (S.K. & F.) 10 cc.	10 a. m.			5 p. m.		9 p. m.	
2/24	101.4° F.	Pentnucleotide (S.K. & F.) 10 cc.	10 a. m.					9 p. m.	
2/25	100.6° F.	Pentnucleotide (S.K. & F.) 10 cc.	10 a. m.					9 p. m.	
2/26	98.5° F.	Pentnucleotide (S.K. & F.) 10 cc.	10 a. m.						
2/27	96.0° F.	Pentnucleotide (S.K. & F.) 10 cc.	10 a. m.						
2/28	98.0° F.								
3/1	95.6° F.								
3/2	98.0° F.								

intravenous injection of 0.45 gm. neoarsphenamine was given while waiting for the arrival of pentnucleotide. Ten cc. of pentnucleotide was injected into the quadriceps extensor muscle three times a day for two days, twice a day for two days, and once a day for two days. The last injection, given during convalescence and in the presence of normal complete blood count, caused a reaction. One week later, at home, 10 cc. pentnucleotide caused a similar reaction and then was discontinued.

She now is living a balanced life as to rest, sunlight, exercise and work, and continues to take neobovinine or phospho muriate quinine and one haliver oil capsule, t. i. d.

Dr. Clarence Steigerwalt made an oral exam-

normal erythropoetic function as follows: Hgb., 84.4%; C. I., 0.9; red cells, 4,490,000; white cells, 6850; polys., 44%; small lymph., 53; large lymph., 3.

Case 3. Male, white, married. Had severe attack of diphtheria in youth. Worked and studied from early life, with much overtime. Busy daily in a professional life for 12 years, 16 to 20 hours a day, 7 days a week. At 36 years of age, though appearing healthy, he would get spells of weakness. This weakness was felt by the patient but not evident to other people, either by appearance or actions. At 38, an afebrile condition developed in which weakness was continuous and the upper right and left posterior gums were thickened, with a sense of agonizing pain. At this time and

for 1 year, the complete blood count showed, as it now does and always did, high red cell count and hemoglobin, but polymorphonuclear count as low as 30 in 100 cells, with as high as 70 small lymphocytes. Cutting his work to 5½ days a week of 12 hours a day for 5 days has changed his physical feelings and blood count to normal.

A fairly large number of my private patients who work overtime, rest little and never play, but eat well-balanced diets, finally become conscious of weakness unusual to them and show mild or moderate neutropenic states in the blood count. Other patients, living similar existences, show in the presence of weakness normal differential counts, hemoglobin, and erythrocytes, but increases of leukocytes to 12,000 or 13,000, without demonstrable focal infections.

Case 1 illustrates what might well be the development of primary pernicious leukopenia with concomitant development of mild cardiovascular sclerosis, after long years of overwork with all that this means.

Case 2 is a typical example of the mild leukopenic state associated with terrific overwork.

Case 3 illustrates a subacute state of primary pernicious leukopenia in a patient in whom all foci of infection had been removed, but who developed the disease apparently as the result of overwork. In this case the disease disappeared symptomatically and hematologically upon the assumption of a more normal existence.

Murphy states that agranulocytosis is a disease of adult life. Jackson, Parker and Taylor, 2 years later, report 2 cases occurring in the first decade of life, 3 in the second, 9 in the third, 11 in the fourth, 11 in the fifth, 17 in the sixth and 3 in the eighth decade. It occurs more frequently in women than in men; one writer gives a ratio of 35 to 1, and another writer a ratio of 5 to 1. Fitzhugh and Comroe in 18 cases treated 11 males and 7 females, a reversal of the foregoing; the ages of their cases were 19 years as the youngest and 68 years as the oldest. Our experience in Atlantic City Hospital covers only 3 cases, all women. One is the woman here reported, apparently a chronic, continuous type, which I hope to

convert into a definite cure. Two other women in middle life died 72 hours after admission and about whose past history so little was obtained that reporting seems not worth while.

PATHOLOGY

The pathology of the disease—gross and microscopic areas of necrosis in the mucous membrane and the underlying muscle—is not different from necrosis produced by other diseases.

Fitzhugh and Comroe in their 18 excellently studied cases found in over 50% a plentiful supply of the progenitors of the blood leukocytes in leukopoietic centers. They state that this virtual hyperplasia is a marked contrast to the profound peripheral leukopenia. This finding seems to confirm their theory of "maturation arrest". Generally, the bone marrow is congested. There is nothing characteristic about the eosinophiles, basophiles or myelocytes, except their absence. This picture confirms the findings of other investigators.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis is concerned with the many diseases above mentioned in which leukopenia is found. Hodgkin's disease and leukemia may prove the most confusing. The course of Hodgkin's disease with further blood and clinical observations will settle the diagnosis. Leukemia, if opportunity for observation exists, will show at some time an increase to a great degree of the lymphocyte total count.

TREATMENT

Treatment is most important to the patient. I believe with Jackson et al, and Jackson and Doane, and others, that pentnucleotide in 10 cc. doses t.i.d., or oftener intramuscularly, should be used and continued as indicated. Doane has demonstrated experimentally that nucleic acid and nucleotides are chemotactic, maturative and initiatory stimuli for neutrophilic myelocytes when the basic mesenchymal tissues from which they arise are in a condition to respond. Clinical response to treatment occurs about the fourth day of the disease irrespective of how long it existed before treatment began, and if then improvement does not begin, a fatality may be expected.

Blood transfusions are beneficial, I believe today. Arsephenamine, dyes, etc., intravenously, are in the discard. Irradiation is dangerous unless done by the most expert.

Cleanliness of necrotic or edematous areas. In my case, because of the presence of fusiform bacilli, sodium perborate and thantiss lozenges were used in an attempt to produce asepsis and local anesthesia of the mouth area.

Not knowing the cause of the disease, I fed the patient blood and liver in the form of neobovine, haliver oil capsules for more vitamins, and a vegetable puree, fruit juice and ground meat diet.

It was surprising how so ill a patient (case 1) could and did eat so much food. Allonal was effective in partially relieving pain and ipral induced satisfactory sleep. The amidopyrin barbituric combination was given on occasion as often as every 3 hours.

CONCLUSIONS

(1) Agranulocytosis is an incorrect term and means the opposite to what is intended.

(2) Primary and secondary pernicious leukopenia describe the disease according to our present knowledge.

(3) Diet should be non-irritating to the diseased areas, but sufficient in calories and vitamins.

(4) Detailed history of the life and habits of patients with primary pernicious leukopenia should be known for a number of years before admission to the hospital for the treatment of an acute attack, in order to better study this disease entity.

(5) Terrific overwork, lack of rest, and recreation followed immediately by work, seem to be important factors in the production of this disease. It must be remembered that constitutional predisposition may explain why one patient acquires a hematologic pathology, another a nephritic pathology, while another stands the strain and dies eventually of old age.

Note: Upon establishing diagnostic proof in Case 1, I telephoned Dr. Richard Kern at the University of Pennsylvania who recommended pentnucleotide administration.

DISCUSSION

Dr. George A. Poland (Pleasantville): Dr. Scanlan's presentation of this somewhat infrequent disease and his report of a case of primary pernicious leukopenia leaves little for discussion of the subject as it is now known. However, it gives food for thought even though the condition, in its primary form, is rare; our discussion must be in the way of elaboration and comment.

Multiplicity of names has caused much confusion. Granulopenia and pernicious leukopenia are most descriptive, and are now the most used terms. But there should be a sharp differentiation between the primary type and those cases developing secondarily to some other condition of known etiology, as acute infectious processes and benzene or arsenical poisoning. Many of the early reported cases were later learned to be of the secondary type.

Its etiology probably arouses our interest the most, because there is yet much to learn of it. Sepsis does not seem to play any part, for the evidence of sepsis is preceded by a low leukocytic count as it naturally would when the barrier to invasion of microorganisms is removed. However, some exogenous factor could still be responsible. Could not a virus, of exogenous origin, or a toxin of endogenous origin affect the granulocytic-producing part of the bone marrow, and produce the condition in susceptible persons? How much fatigue may have to do with producing a susceptibility is brought out in the history of Dr. Scanlan's patient, who had been subject to severe fatigue, possibly mental as well as physical, for a long period of time. There is another patient reported in the series of H. Harkins, who suffered two attacks, dying in the second. These attacks were a year apart and both were concurrent with severe fatigue.

Diseases of the hemopoietic system of little or unknown etiology are known to have a tendency to chronicity or recurrent attacks. The time elapsed since the reports of patients who have recovered from the first attack of primary pernicious leukopenia, is too short to be able definitely to forecast possibility or frequency of recurring attacks.

It will be interesting to learn in the future whether the regulation of life, prevention of fatigue, and similar factors, do prevent a recurrence of the disease in Dr. Scanlan's case.

While this disease is rare, it is doubtless increasing; as to the number of cases that may go unrecognized, or diagnosed as Vincent's disease, it would be difficult to wager a guess. To have such conditions brought to the minds of those of us in general practice is helpful, for we know not when it will be useful.

Permit me to thank Dr. Scanlan for the impression his paper and report have left with me.

Dr. Samuel Barbash (Atlantic City): A few years ago, Dr. Schultz described a disease or entity which he called agranulocytosis. Since then, like a snowball which rolls down hill and gathers momentum, the number of cases of agranulocytosis is increasing.

What is agranulocytosis? When Dr. Scanlan

read his paper, he opened up a subject in which there is plenty of room for discussion.

If this problem is approached from the viewpoint of symptomatology, we must admit that any case which gives high fever, chills, general malaise, muscle pain, marked prostration, extreme gangrenous stomatitis or ulceration in some other portion of the alimentary tract, with the concomitant blood picture so well known, must be agranulocytosis or malignant neutropenia. If, on the other hand, our diagnosis is made from the etiologic, or rather lack of etiologic, standpoint, we are confronted with the problem of calling any case in which we are able to find a cause as not true agranulocytosis, because it is the opinion of some that this disease is only the result of a profound, definite toxin of unknown origin.

Some authors, particularly Loen, differentiate what they call symptomatic angina, which results from a known infection or from exposure to such substances as benzol or radium.

The question of etiology has been fully discussed by Rose, Houser, and Blumer. Separation of this syndrome as a specific disease entity has been seriously questioned.

It may well be asked whether this syndrome represents a primary disease of the granulopoietic apparatus with secondary necrotic foci, or whether there is a reaction to an overwhelming septicemia in a person with low resistance.

Ordway and Gorham cite 3 cases where the blood picture was present before changes in the tissues appeared. Roberts and Kracke found that blood changes occurred in their patient before symptoms appeared. Rutledge, Hansen-Pruss, and Thayer re-

port a patient who suffers from cyclic attacks of granulocytopenia.

The cause of the bone marrow paralysis in these cases can only be surmised and the presence of a profound toxin suspected. Most observers feel that granulocytopenic angina is a non-specific reaction to infection of unusual virulence and that a variety of organisms may cause it. They have proposed the name of septic agranulocytosis.

Others, particularly Fitz Hugh and Comroe, as pointed out by Dr. Scanlan, believe that it is a disease entity. However, it is so closely simulated by certain other conditions that its status may remain debatable until a potent, specific therapy is available, or some pathognomonic feature is discovered.

Musser has discussed the reaction of the leukopoietic system to various types of throat infections, and has shown that these reactions may vary from a leukocytosis, with an increase in polymorphonuclear cells, to the type found in Schultz's disease.

The occurrence of granulocytopenia with leukopenia in association with a large variety of poisons and septic causes may also be cited as an example of the non-specificity of the disease.

Treatment so far has been unsatisfactory, as most cases do not recover. Where a cause is discoverable, it should, of course, be treated; where none is found, the treatment is, of necessity, symptomatic. Pentnucleotide has been of some value, although in the experience of Fitz-Hugh and Comroe, it is valueless in chronic cases. They report in a series of 18 cases, 78% of deaths; all but 4 have died, and only 2 of these 4 could be considered cured.

THE DIABETIC PROBLEM

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HISTORICAL

Diabetes has been recognized as a disease entity since the first century of our era. In the oldest existing medical document except the Hippocratic writings, Celsus, a Roman physician of noble family, about the middle of the first century described a disease characterized by polyuria, weakness, and loss of weight.

Artacus, a Greek physician of Cappadocia, about 150 A. D., first used the term diabetes—meaning a siphon—to describe a disease in which thirst, polyuria and emaciation were the prominent symptoms. Galen, the great physi-

cian, who began practice in Rome in 164 A. D., was familiar with this disease.

It was not until 15 centuries later, however, in 1674, that Thomas Willis demonstrated the sweetness of the diabetic urine. He says, "But as to what several authors say that the Drink is little or nothing changed, there is no truth in their suggestion: because in all People—that I ever happened to know, and I believe it to be so in all—their urine was very different not only from the Drink that they took in, but also from any other humors that are usually generated in our Bodies, being exceedingly sweet, as if there had been Sugar or Honey in it."

In the year of our Declaration of Independence, 1776, Matthew Dobson, of Liverpool, proved that this sweet taste was due to sugar. He evaporated two quarts of diabetic urine and obtained a cake of sugar weighing two ounces—3% sugar.

The disease was first identified with pancreatic function by Minkowski and von Mering in 1889, by demonstrating that complete extirpation of the pancreas in animals caused a permanent diabetes. In 1900, Opie and others pointed out the association of degeneration of the islands of Langerhans with diabetes. And finally, in 1921, Banting and Best discovered insulin.

Naunyn in 1898 began the modern dietetic treatment of diabetes, by emphasizing the value of fasting days. His most enthusiastic follower was Allen, who introduced prolonged fasting, followed by a low caloric diet, as a system of treatment. With the exception of insulin, the principle of under-nutrition is the most important contribution to the treatment of diabetes made in this century.

Many drugs have been used in the treatment of this disease, but alcohol and opium appear to be the chief ones until the introduction of insulin. As late as 1916 Osler said, "Opium alone stands the test of experience as a remedy capable of limiting the progress of this disease."

GROWING IMPORTANCE OF THE PROBLEM

The death rate from diabetes has increased so rapidly during the past 50 years that it has now assumed the proportions of a major public health problem. The death rate in New York City has risen from 3 per 100,000 in 1866 to 26 per 100,000 in 1931—an increase of over 800%! During this same period the death rate from "all causes" has fallen steadily. Most of this disease in the mortality rate from "all causes" is due to a reduction of infant mortality and the control of infectious diseases such as diphtheria, typhoid and tuberculosis.

In any event, the decline in the general death rate as well as the addition of from 15 to 20 years to the average span of life, is due almost entirely to a decrease in the number of

deaths taking place before the middle years of life.

In 1789, two years after the adoption of our present Constitution, and before any amendments in the interest of public health were thought necessary, the expectation of life at the age of 50 was 21.16 years. Today the expectation of life at 50 is 21.54 years—an increase of 38/100 of a year, or less than 5 months, as a result of 150 years of effort!

It seems to be clear that, if we are to lengthen the span of life, we shall have to attack those diseases that cause men to die after middle age. Diabetes is one of those diseases. It is most distressing that the death rate from diabetes has risen sharply since the introduction of insulin! These rates concern mortality only; at present there exist no accurate figures regarding the incidence of diabetes. Dublin says, however, that "there is every reason to believe that the number of cases have increased much faster than the deaths".

To add to our perplexities, the anti-vivisectionists point out that the recent increase in the death rate began when insulin was introduced, assert that the use of insulin is responsible for these deaths, and flaunt the official figures in our faces to support their contention. On analysis, however, this *post hoc ergo propter hoc* argument fails as usual.

The total death rate from diabetes in New York City, according to official figures, unquestionably shows this distressing increase. When these rates are analyzed according to age and sex, some very interesting facts appear. We find, for example, that the sharp rise in mortality which has occurred in the past 10 years occurs between the ages of 45 and 65 years in both sexes, and, curiously enough, the death rate in women is rising much more rapidly than that in men. At present, in this age group, more than twice as many women as men die of the disease. In the age group under 35, however, there has been a steady reduction of mortality in both sexes since the introduction of insulin. This decline in the death rate would have been even greater if insulin had been used in every instance. In 1925 the Metropolitan Life Insurance Company, reporting on 1900 fatal cases, found that insulin had been used in less than half of the

cases! Four years later 63% had received insulin. The most striking decrease in mortality since the introduction of insulin, however, occurs between the ages of 5 and 24 years. In this group the death rate is less than one-third of what it was in 1920. These figures can mean only one thing, namely, that insulin has proven itself a life-saving measure in childhood and early adult life.

Moreover, when we investigate what complications of diabetes are the immediate cause of these increasing diabetic deaths, some very illuminating facts appear. Those complications which can be controlled or prevented by insulin are diminishing as a cause of death, while those complications which cannot be controlled or prevented by insulin are increasing. Deaths from diabetic coma have decreased from 60% to 20% since the introduction of insulin—some recent figures are even as low as 10%. Pricilla White says, "Deaths from diabetes in children in Massachusetts have almost reached the vanishing point." The death rate from carbuncle in diabetics has fallen from 50% to 10% since the introduction of insulin. In other words, deaths due to coma, for which insulin is a specific, have declined steadily since the introduction of insulin. On the other hand, deaths from cardio-arterio-renal complications, which are unaffected by insulin, have increased from 13% in 1914 to 52% in 1931—an increase of 400%.

Furthermore, the rise in mortality rates among older persons since the introduction of insulin is more apparent than real. By a ruling of the Department of Health of New York City, diabetes as a cause of death takes precedence over the other diseases noted in a death record except in deaths from diphtheria, typhoid, tuberculosis and the acute infections. This means that if diabetes is reported as a contributory cause of death occurring from any of the so-called degenerative diseases, the death is recorded as due to diabetes. But this ruling of the Department of Health has been in force a great many years. Why then should this tremendous rise in mortality among older diabetics occur only since the introduction of insulin? The obvious answer is that insulin is enabling more and more diabetics to attain

ages at which it is natural to die of a degenerative disease.

CAUSES

(1) The essential cause of diabetes is unknown. There are, however, several factors which appear to contribute to its onset. The most important of these is *obesity*. Obesity, certainly, is a factor in diabetic deaths, for Dublin has shown that extreme overweights have a mortality $8\frac{1}{2}$ times in excess of normal weights, and 13 times the rate shown in underweights—he is speaking of diabetics only. Rabinowitch, of the Montreal General Hospital, puts it very tersely when he says, "Insurance statistics have shown that when a man adds 10 pounds to his belt line he subtracts 1 year from his life line."

(2) *Heredity* appears to be a factor in the incidence of diabetes. Joslin's figures for this year show among his children a positive hereditary factor in "over 50% of the cases". Unquestionably, a more careful search in our histories for an hereditary element will find it present. Sometimes the reason it isn't found is, that it has not yet developed in the parent when we look for it. Among 18 of Joslin's diabetic children with a diabetic parent, there were 6 instances in which the disease appeared in the parent *after* it had appeared in the child.

(3) *Age*, as we have seen in reviewing New York City's mortality statistics, is a factor in determining the onset of diabetes. By far the greatest number of cases occur in the fifth and sixth decades. Perhaps the increasing death rate among women after 50 is due to the obesity which so often accompanies or follows the menopause.

(4) It has been claimed that *race* plays a prominent part in the incidence of diabetes. In the United States Census of 1890, deaths from diabetes were 7 times greater among Jewish males, and 16 times greater among Jewish females than in the general population. Dr. Haven Emerson believes this racial predominance may be due to the sedentary occupations, lack of physical exercise, and tendency to obesity of the Jews. The death rate from diabetes among American negroes who have moved to northern cities is twice that of the same people

in the South. May this not also be due to their changing living and dietary habits? Reliable figures for the rice-eating peoples of the Far East are not available.

(5) *Occupation* appears to have no relation to the incidence of diabetes, except in so far as it might favor obesity which accompanies a sedentary habit of life. The most recent figures from the Metropolitan Life Insurance Company for mortality show that "merchants" head the list. (This may have a bearing on the apparent prevalence among Jews.) Figures for England and Wales give "innkeepers" the first place. On both lists, "manual laborers" show the lowest death rate. French experience is similar.

(6) The *changing dietary habits* of the American people have been the subject of much critical analysis during the past few years. A diet in which meat predominated has been replaced by one consisting mostly of cereals, fruit, vegetables, and dairy products. At the same time the per capita consumption of sugar has increased enormously in the past 60 years, having risen from 32 pounds in 1870 to 107 pounds in 1925—an increase of over 300%!

One is tempted to assume that the increasing incidence of diabetes is due largely to this increasing sugar consumption, for there is a rough parallelism between the two curves. There are, however, one or two discrepancies that must be explained. For example, in the decade from 1915 to 1925 the diabetic death rate in New York City increased *less rapidly* than it had during any previous decade in this century. During this same period the per capita sugar consumption in the United States increased *more than twice as rapidly* as it had in any decade up to that time.

Lack of time does not permit me to go into this discrepancy thoroughly, but I believe it can be accounted for on the basis of two important events that occurred during that decade—namely, the war and the influenza epidemic. We know that the death rate from most diseases with the exception of influenza, declined for a year or so following the epidemic. Diabetes was one of the diseases thus affected. Moreover, we know that during the war years some 8 or 10 million more Americans than

usual were engaged in hard manual labor in the training camps. When it is considered that in all countries for which reliable figures are available, the lowest diabetic death rate occurs among manual laborers, this increase in the ranks of laborers in America probably accounted for a considerable decline in the diabetic death rate.

Another exception that occurs in the parallelism between diabetic mortality and sugar consumption appears in the statistics from abroad. The sugar consumption in Denmark is over twice that in Norway, yet the diabetic death rate differs by only 3 per 100,000—a negligible amount. I do not attempt to explain this difference.

In spite of these exceptions, however, I believe it will be found that increased sugar consumption, combined with over-eating in general, has a bearing on the increasing incidence of diabetes in this country.

(7) Another important factor is the *migration* of the American people from rural sections, where manual labor is the rule, to cities, where it is the exception. We know that among one group of our people, the negroes, this migration has been accompanied by a 100% increase in mortality from diabetes. We may reasonably assume this to be true of the other races.

(8) *Infection* always aggravates existing diabetes. In carefully compiled histories, especially in children, it will be found that the onset of diabetes is frequently preceded by an acute infection. Unless the infection includes a pancreatitis, however, it should probably be regarded merely as a precipitating factor in the onset of the disease, rather than the actual cause. In the general population, unless what might be called the diabetic diathesis exists, the vast majority of acute infections are *not* followed by diabetes.

(9) *Endocrine imbalance* may be a contributing factor in the onset of diabetes. We know that a disturbance in carbohydrate metabolism occurs in thyroid and pituitary disorders and occasionally during pregnancy. Diabetic children show a marked disturbance of carbohydrate metabolism at puberty. Diabetes, itself, is a disease of the endocrine system, and it may be that further research in this fertile

field will reveal the actual, immediate cause of the disease.

(10) Finally, *psychic or nervous shock* has been thought to be a contributory cause of diabetes. It has been proved that *emotional stress* affects the glucose metabolism even in normal persons. In any event, may it not be true that the increasing stress and strain of modern urban civilization is an important factor in the increasing incidence of diabetes in our cities?

While a review of these 10 contributing factors to the onset of diabetes does not solve the diabetic problem, it is hoped that a further study of them may throw some light on the essential nature of the disease, and help us to combat its growing incidence and mortality.

RECENT ADVANCES IN OUR KNOWLEDGE OF DIABETES

In the past 10 years there have been important changes in our approach to the diabetic problem. Perhaps the most important, except for the introduction of insulin, is the *changing ratio of fat and carbohydrate* in the diabetic diet.

Statistically, we have seen that the greatest decline in mortality since the introduction of insulin has occurred between the ages of 5 and 15. Formerly no diabetic children lived through *adolescence*. Now, that we can keep these children alive with insulin, we see the reason why. The insulin requirements of children, especially girls, approximately double at puberty, and, so far as we know, remain at that level.

Arterio-sclerosis has been shown to develop earlier in diabetics than in non-diabetics. In 1926, Morrison and Bogan in Boston x-rayed 324 diabetics and found evidence of arterio-sclerosis in 30% between the ages of 20 and 29; and 45% between the ages of 30 and 39. Using the same method on non-diabetics Bowen noted an incidence of 0.5% in these age periods. This marked difference is thought by some to be due to the high fat diets that were formerly employed, but the whole question of fat metabolism in its relation to diabetic arterio-sclerosis remains to be settled.

It has been shown that more diabetics live to the *coronary age* than formerly, but it remained for Nathanson, of the University of Minnesota, to show by autopsies of 100 diabetics that "the incidence of *coronary sclerosis* is approximately six and a half times greater in diabetics than in non-diabetics". This acquires added significance when we remember that insulin has to be used carefully in these cases, for the coronary heart is particularly susceptible to hypoglycemia.

In the treatment of *diabetic coma*, the trend now is to give more insulin in the early stages than formerly. It is my practice now to give a unit of insulin per kilo of body weight as the initial dose in coma. Insulin is then given every half hour in diminishing amounts until the acidosis is under control. During this period, which lasts usually from 2 to 6 hours, fluids are forced by all channels, but no carbohydrate is given. In children, while the initial dose of a unit of insulin per kilo can safely be employed, the subsequent doses are much smaller, and must be calculated for each individual case.

To date, no adequate *insulin substitute* to be taken orally has been discovered. Myrtillin and synthalin had their day; they appeared to exert a slight effect on glucose metabolism. Synthalin, however, produced gastric disturbances, and neither was effective in cases which were not mild enough to be controlled by diet alone. Liver is reported by Murphy, of Boston, to be an insulin saver, 500 gm. being equivalent to 5 to 10 units of insulin. A common insulin sparer, which we all use, is exercise. Indeed, undue exercise is so effective that it will produce an insulin reaction in a patient otherwise balanced as to carbohydrate and insulin.

The search for an insulin substitute to be taken by mouth will continue. It may be that one will be found, thus releasing diabetic patients from the thrall of the hypodermic. Joslin believes, however, that it may not prove to be an unmixed blessing, for it will make it too easy for the patient to overeat, and may thus create new and more complicated problems.

SUMMARY

The diabetic problem is reviewed with special reference to:

(1) An analysis of New York City mortality statistics which shows that: (a) Since the introduction of insulin the death rate has declined in the age groups under 35 years and

has increased in the age groups over 45 years.

(b) An interpretation of these statistics suggests that the enormous increase in the death rate may be more apparent than real.

(2) A review of the factors which contribute to the onset of diabetes.

(3) A brief discussion of recent advances in our knowledge of diabetes.

THE PANCREAS AS A BLOOD PRESSURE REGULATOR

A Preliminary Report

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From the time that Fairve, in 1856, applied the sphygmomanometer for measuring blood pressure, both the physician and the laity have become interested in that subject. Many explanations have been offered for the variations of blood pressure from the normal, and much has been written about the relation of certain glands of internal secretions to variations in blood pressure. There is, however, very little, if anything, in the literature about the relation of the action of the pancreas to the rise and fall in blood pressure. It is the purpose of this paper to prove the relationship of the pancreas and its secretions to changes in blood pressure from the normal.

By observing the behavior of certain pathologic conditions in which the pancreas is one of the organs involved, one cannot help feel that there is a direct relationship between normal action of the pancreatic secretion and variation in blood pressure. As a preliminary study of this subject, two large groups of patients must be recognized.

Group 1. The Hyper-pancreatics, or those patients in whom there is an increased secretion of the pancreas including insulin and who show symptoms bordering on mild shock.

Group 2. The Hypo-pancreatics, or those patients in whom the pancreatic secretion is below normal and ultimately show signs and symptoms of hypertension. In this class are included the so-called (a) Hypertension and (b) Diabetes Mellitus.

Under one group are the hyper-pancreatic patients who have forms of relative hypotension. I wish to discuss at this point, a large group of persons who have a pressure of about 100/55 to 70. Most of them belong to the asthenic type of person. Their performance capacity is limited. Among them may be many who have no complaint so long as the stress of modern civilization is limited to their constitutional capacity to carry on. They recognize their inability to tolerate stress in work and play that more robust persons stand with apparent impunity. As long as they live within their limitations, all goes fairly well. Others, by accident or otherwise, become subject to extreme anxiety, worry or fear. These asthenic persons do not tolerate conditions which force them to go beyond their limits; as a result the strain affects the autonomic nervous system with marked depreciation in health.

The sympathetic nervous system is the driving force in all our activities, emotional and otherwise. Eventually, fatigue of the sympathetic nervous system occurs which results in an atonic condition that is followed by hyper-irritability of the para-sympathetic or vagus. In this condition, called vagotonia, we have a striking group of symptoms, including hypotension. Clinically, these patients come to us complaining of overwhelming fatigue which occurs after slight effort. They have often been told that their blood pressure is low and that is the chief cause of their trouble, or that they

have neurasthenia and must either rest or exercise to recuperate. The hypotension is a result of sympathetic fatigue. The hypotension fatigue and lack of endurance can be explained as due to hypoglycemia from overstimulation, resulting in increased secretion from the pancreas, including insulin.

Some of these patients present symptoms bordering on mild shock, reminding us of symptoms that occurred from an overdose of insulin, before the insulin unit and proper dosage had been developed. In most patients presenting this unusual fatigue, the fasting blood sugar is below 90. If we subject them to the glucose tolerance test, the blood sugar will practically always be lower than normal, and usually in the second or third hour a definite hypoglycemia of 70, and as low as 45 or 50 mgms. per 100 cc. of blood, is found. During the course of the sugar tolerance test, some will have a typical hyperinsulin reaction. Another interesting fact is that these patients all have a definite hypometabolism, often as low as 15 or 20. This is best explained by fatigue of the sympathetic side of the autonomic nervous system. Nearly all of these patients have a spastic colon due to hyperirritability of the vagus and have definite constipation. Dr. Mortensen, of Battle Creek, has proved these results in over 50 patients.

This group of symptoms may develop in the asthenic type of individual, as a result of some unusual physical strain. In the first place, these patients must adopt a program regulating their activities, so as to remain always within their limitations and thus avoid the usual fatigue.

Because of the tendency to hypoglycemia and associated fatigue, frequent meals are indicated. The total intake of food may not need to be increased unless the patient is underweight, but by taking food between meals the glycemia may be avoided. Milk, butter, orange juice or candy may be taken. Because of the hypo-adrenalemia, suprarenal extract is given, often in large doses; in severe cases as much as 30 or more grains a day. This is continued for months and sometimes for years. In cases which occur in fairly robust persons, as a result of over-work or some acute infection as influenza, the programs here outlined give rather prompt results.

By a careful study of our neurasthenic patients, I believe we shall find many belonging to this class who have a definite pathology suggested by the arterial hypotension and the hypometabolism. These findings should be a definite aid in instituting proper therapy. It is interesting to note that the above findings are found in Addison's disease and the therapy suggested is very similar.

In the other group are the hypo-pancreatic patients with hypertension. In patients with gall-bladder disease it is well known that most of them are cases of hypertension. Of those who come to operation, in the majority the pressure will drop as soon as the postoperative convalescence begins to show itself. It is due, no doubt, to the relief given to the congested and inflamed pancreas. When the pancreas has regained its normal activity the blood pressure will fall, i. e., the period of hypo-pancreatism has ended. The blood pressure of these patients remains normal or near normal. If their gall-bladder symptoms return, their hypertension returns.

Diabetes Mellitus, a disease of metabolism in which the normal utilization of carbohydrates is impaired, is due to a disturbed function of the internal secretion of the pancreas. Eighty-five to 90% of the patients suffering from diabetes show a rise in their systolic and diastolic blood pressure. When the hyperglycemia is controlled with diet and insulin, there is a drop in the diastolic pressure and, occasionally, in the systolic.

Assuming that the hypertension group is the so-called group of Hypo-pancreatics, it is necessary to find out what will be the result of feeding these patients a high carbohydrate diet, adding some form of pancreatic extract which would either stimulate the pancreatic secretion, or else aid the digestion of these carbohydrates, or at least those which would normally be poorly digested with the resulting usual symptoms of hypertension.

Patients were picked at random in the Cardiac clinic of the Mountainside Hospital, Montclair. Nine patients in all were observed; most of these were complicated cases, i. e.: (1) Old arteriosclerosis with nephritis; (2) aortic disease; (3) essential hypertension. They all complained of the usual symptoms,

such as: (1) Pain in back of neck, i. e., occipital headache; (2) dizziness; (3) spots in front of eyes; (4) shortness of breath.

As they came to the clinic they were permitted to go 1 week without medication but given a regular diet; when they returned to the clinic the following week they were given a diet which was "salt poor and high carbohydrate"—

Protein	60-70 Gms.
NaCl	2.5-3 Gms.
Fluids	800-900 cc.
Calories	2000-2200.

In addition, each patient was given a 4-ounce bottle of a pancreatic extract, for oral use, prepared especially for this purpose from the fresh (not frozen) gland without heating, drying, or using alcohol extractives. This pancreatic substance given to a normal patient whose blood sugar was 120 on a starving stomach, reduced the blood sugar to 100 after a breakfast of 1 orange, a bowl of cereal, 2 eggs, 2 rolls and butter. The patients were told to take 2 drams of the extract in milk or water with each meal. Those who were unable to follow the diet were advised to eat their regular daily meals and to add 3 oranges or 3 apples to their diet.

The result after 1 month showed that each

patient lost 2 to 4 pounds. They all felt generally better; headaches were less. Blood pressures invariably showed a drop in the diastolic pressure to below 100. Four cases showed a drop of 10 to 20 mm. in the systolic pressure after 5 months.

All of these patients are symptomatically better; all express themselves as feeling better now than in the past 1 or 2 years. The diastolic pressures have stayed lower and the systolic pressures have either remained unchanged (in the old sclerotic cases) or dropped 10 to 30 mm. in the essential hypertension and so remained.

CONCLUSIONS

- (1) The pancreatic secretions have a definite relation to blood pressure variations.
- (2) An excessive pancreatic activity will create hypotension with consequent symptoms of mild hypoglycemia.
- (3) A diminished pancreatic activity is observed in cases of hypertension.
- (4) Hypotension cases are benefited by a high and easily digestible carbohydrate diet.
- (5) Hypertension cases are benefited by a low salt and relatively high carbohydrate diet with a pancreatic extract to aid carbohydrate digestion or stimulate pancreatic activity.

RELATIONSHIP BETWEEN HOSPITAL TRUSTEES AND THE MEDICAL STAFF

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I have listened with great interest to the able and scholarly discussion of the relationship between hospital trustees and medical staff, presented by Dr. William Cutter, Secretary, Council on Medical Education and Hospitals of the American Medical Association. I approach my own task with the natural diffidence of a layman in the presence of physicians. After all, the healing profession has

for years had a monopoly on that impressive technical vocabulary in which a cold appears as "coryza" and dizziness as "vertigo". It is only recently that we, of the laity, have begun to develop our own jargon of technocrats, conservators, rehabilitators, coördinators and other names wherewith to confuse and impress the public.

Nevertheless, despite our comparative verbal amateurishness, I feel that Dr. Cutter has not, in his excellent survey, given quite enough

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credit to us of the laity for the remarkable progress of the hospital movement. Not alone the advance of scientific knowledge has served to overcome the former public aversion to hospitalization; the vast improvements in management of our institutions, for which our boards of directors have been responsible, has also played an important part in convincing the public that they can find in the hospitals far better care for operative or other medical conditions than in their homes.

From a business point of view, hospital efficiency has been gravely hampered by the total lack of planning in hospital distribution. In New York, for example, our first public hospital sprang into being in 1736 on the present site of City Hall, with six beds and a small clinic. Shortly thereafter New York Hospital was built, both these institutions serving, as Dr. Cutter has suggested, as adjuncts to the poorhouse, their avowed purpose being to care only for the indigent sick. The following century, however, witnessed the growth of a different kind of institution—hospitals built and financed by various fraternal organizations, sectarian and foreign-born groups. These institutions were not based on the obvious logic which made the charitable hospitals a community necessity. Frequently they were an expression of group or racial pride, or the result of whimsical bequests. In any event, these hospitals have not been planned with a scientific regard to community needs. The result has been that, in New York, there are numerous localities with a superabundance of hospital beds and a dearth of patients, while the hospital facilities of other districts are far from adequate. This deficiency in planning is, to my mind, one of the major problems for hospital trustees to conquer.

Broadly speaking, my conception of a trustee's responsibility is far more radical than that expressed by Dr. Cutter. In my opinion, there should be a very exact and severe demarcation of function in any hospital organization; that is, all matters coming under the head of business or managerial problems are the trustees' province, whereas all professional matters are entirely under the jurisdiction of the medical board. Naturally, since the selection of the medical board must originally ema-

nate from the trustees, ultimate authority is vested in them. Once the medical board has been chosen, however, I believe in a strictly hands-off policy. The trustees must express their confidence in the medical board of their choice by allowing that body complete freedom in the regulation of professional matters.

For this reason, I do not concur that "the medical board should be consulted about appointments". In my opinion, the medical board should *make* the appointments, the trustees acting only as a rubber stamp to pass on the purely non-professional qualifications of a candidate, such as his moral and social integrity. Further, I believe it is incumbent upon a board of trustees to abstain in every possible way from suggesting or urging the appointment of medical candidates of their choice. Only in this way can a hospital be kept free from the atmosphere of political intrigue whose devastating effect upon professional morale cannot be exaggerated.

Because of my firm conviction that professional men should and must assume responsibility for professional matters, I am forced to take issue with Dr. Cutter's suggestion that the board of trustees see to it that every physician practicing in a hospital limit his activities to those fields in which he is proficient. In my opinion, there is no conceivable way whereby the board of trustees can assume this responsibility. Let us assume that we have on service a perfectly capable nose and throat specialist who has performed a tonsillectomy on a retired business man, getting a rest cure in a private pavilion. Shall I, as a trustee, personally determine that this nose and throat man shall not prescribe for an expensive "tummy ache" or possible rheumatism? Obviously, this is a responsibility of the medical board alone. If I have a medical board on which I cannot rely for such fundamentals, the sooner I get rid of them the better.

Because such confidence is, to my mind, an absolute necessity, I feel very strongly that open hospitals are, in a community of any size, absolutely undesirable. I grant that they may be unavoidable in very small towns; but, in cities such as I have known, a closed institution is the only one in which a high standard of professional conduct can possibly be main-

tained. What does it mean to allow every so-called reputable physician in the community the use of a hospital's facilities? A reputable physician, so far as I can find by legal definition, is one who has never been in jail and is duly licensed by the State. Despite the high esteem in which I hold the profession as a whole, I should not care to assume responsibility for the acts of any so-called reputable doctor. Nor do I believe that I would be fulfilling my duty as a trustee unless I have some check on the caliber of my medical staff, which, in an open hospital, is impossible.

To my mind, there is so clear a demarcation between lay and medical functions in the operation of a hospital, that I am strongly opposed to members of the medical staff being on the board of trustees. I approve thoroughly of the physicians sending their representative to board meetings to interpret the professional viewpoint to the board, but I do not believe that these representatives should have a vote or a voice in the business management of the institution. My reason for this is twofold. First, I have found that the doctor businessman is generally either a second-rate doctor or a second-rate businessman or both. He is, therefore, not qualified, except in rare cases, to pass judgment on purely business problems. In the second place, I feel it is unfair and unnecessary to burden the professional staff, whose scientific duties should command all their time and attention, with matters which are the rightful responsibility of the trustees. Certainly a medical board would rightly resent the presence of laymen in its councils; quite as correctly, there is no place for medical men on the board of trustees, providing that the board understands and fulfils its duties.

Nor do I think that any such conflict could possibly arise if the average board of directors were as conscientious and as thorough in carrying its share of the burden as is the average medical board. The typical trustee, so far as my own experience goes, is a reasonably successful businessman who must have a practical knowledge of business principles, at least for the conduct of his own affairs. If he would view his hospital duties in the same business-like fashion, he would find that his job as trustee called for two distinct duties. First, it is

his job to see that the hospital has ample funds for its purposes. Second, he is called upon to lend his aid and supervision to all the practical aspects of the hospital's work. This is a serious task. In the metropolitan district of New York, our hospitals have an appraised valuation of over \$170,000,000 and spend annually more than \$61,000,000. To raise and administer such a fund is a large-sized responsibility with which it is totally unfair to burden professional men who have exacting scientific duties to meet and who have neither the qualifications nor the desire for business responsibility.

Further, I believe that if trustees more fully appreciated the extent and seriousness of their responsibilities as laymen, they would be less eager to have a finger in the medical pie. I know of nothing more demoralizing than the deplorable tendency of trustees to urge and sanction the appointment of their friends and relatives to a medical staff which is not rightfully under their jurisdiction.

I am unalterably opposed to any intrusion by trustees into purely professional matters, even when they may affect the apparent balancing of a private pavilion budget. I must confess, however, that I have never, in my limited experience, heard of trustees going so far as to urge or cause unnecessary operations in order to fill up beds in private rooms or wards. So far as I can discover, by fairly extensive inquiry, this is a completely groundless accusation, and I cannot imagine what the mechanics of such a procedure would be, nor what could be the professional standards of any physician or the mental rating of any patient who would submit to operation at the instigation of a trustee.

Although I have never heard of or seen an actual case of this kind of commercial and wholly immoral activity, I am familiar with the more usual types of pressure exercised, and I find them almost as deplorable. I am sure that we all know of physicians who were promoted and attained high rank, simply because they enjoyed lucrative practices which kept private pavilions filled, while other doctors, far better qualified from a scientific standpoint, were passed over.

This kind of policy cannot be deplored too

strongly. Anything beyond the legitimate request that staff members whenever possible send their cases requiring hospitalization to the institution with which they are affiliated, should be and is severely barred by any intelligent board of trustees. Any institution that must resort to using its professional staff as business-getters, cannot do so without a grave sacrifice of professional standards.

On the other hand, I think a board of trustees has a legitimate grievance when members of their own medical staff indulge in the increasingly prevalent custom of setting up private profit-making sanatoria to which they divert their own cases. It is my belief that the recommending of unnecessary operations is a far more usual practice in these establishments than in any of the philanthropic institutions with which I have ever been affiliated. I will grant that a physician has no pecuniary obligation to an institution which he serves free of charge. On the other hand, he does profit from the prestige which his hospital appointment carries with it; and to that extent, it seems to me justifiable to ask that he send his hospitalized cases to the institution which sheds upon him whatever lustre there may be in a staff appointment.

For, after all, the board of trustees has even less obligation to the hospital than the medical staff. There is comparatively little glory in being a director, and it is generally an expensive recreation. Furthermore, the hospital is not in business for profit. It is performing a humane, public service at the expense of a group of private philanthropists.

In this connection, I would like to emphasize what appears to me an unfair abuse of the hospital's philanthropic purpose; namely, workmen's compensation cases. It seems to me that medical boards and trustees must assume a joint responsibility for a far from just or equitable situation. Recently I had the privilege of serving a chairman of a committee appointed by Franklin D. Roosevelt when he was Governor of New York State. The study made by this committee of medical and hospital problems in connection with workmen's compensation, revealed that the payment made by insurance carriers to hospitals for compensation cases did not, by any means,

cover the actual cost of care. Our investigation further revealed that our compensation act was conceived as a piece of social legislation designed to prevent the pauperizing of victims of industrial accidents. We found, however, that under the current system of payment to hospitals, the burden was being carried, not by insurance, but by the community which supports hospitals.

It is my understanding that you in Essex County have established a uniform rate of \$4.50 per diem for bed care, which is approximately your cost. We, in the metropolitan district of New York, still have varying charges and, on the whole, there is a large discrepancy between the actual cost to the hospital of bed care in workmen's compensation cases and the amounts received from the insurance companies. In other words, funds contributed by the public and by trustees for philanthropic cases, are being diverted to make up the difference between the cost and the amount paid by carriers.

In many institutions, the trustees have been anxious to receive compensation cases on the theory that a bed paying something, even if less than cost, is better than an empty bed. Medical boards, on the other hand, have been receptive to compensation cases because of the medical and surgical fees involved. I think that neither of these points of view justifies perpetuating an illogical system of payment to the hospitals. As a trustee, I am only too glad to give free care to indigent and deserving cases in which, I am sure, the medical board concurs. Physicians have always been more than generous in contributing their services. Neither of these facts, however, justifies an attempt to attract to hospitals, cases which the charitable public subsidize for the benefit of insurance companies. If premium rates, under existing policies, are not high enough to pay actual cost, they should by all means be raised, but neither trustees nor medical boards should be asked, in the name of charity, to care for industrial cases specifically insured under the workmen's compensation act.

In this connection, I believe that President Roosevelt's recent message to Congress, suggesting a railroad coördinator, could be use-

fully applied to the field of workmen's compensation. I believe that the appointment of an insurance coördinator might do much toward eliminating the expense of adjusters, claim agents and separate medical boards, as well as unearned commissions, which constitute an unnecessary and wasteful duplication in this era of economy and readjustment. Conceivably, a state fund monopoly would eliminate many existing abuses of the workmen's compensation act, resulting in more adequate treatment for the injured, more equitable recompense to institutions and professional men, and a more satisfactory solution of the entire problem for society as a whole.

These are problems for trustees and medical boards to solve jointly. Despite the intangible human element involved, I think that these and other questions of hospital organization can best be met on a strictly business-like plane.

For this reason, I cannot follow Dr. Cut-

ter's analogy that the relation of trustees to medical board be that of man and wife. This may be because I retain an old fashioned aversion for too-frequent divorce, or because I have greater faith in the harmony of a strictly business-like relationship. It seems to me that an ideal relation of directors to physicians can be similar to that of executives to technicians in a great engineering or manufacturing corporation—a relationship based on mutual confidence, and a mutually satisfactory division of function. That relationship need not necessarily be permanent. It should be terminated at any time when either group, by a tendency to intrude on the province of the other, demonstrates that this necessary confidence no longer exists. It seems to me that, so viewed, on an unromantic and business-like plane, the two governing groups of a hospital can achieve, to a far greater extent, the ideal of a humane and efficient service for which they exist.

VASOMOTOR RHINITIS FROM THE STANDPOINT OF THE ALLERGIST

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Vasomotor rhinitis is a pathologic condition, the chief symptoms of which are nasal congestion, irritating, watery rhinorrhea and sneezing. It includes hay fever, in which the symptoms recur annually due to inhalation of a pollen to which the patient is hypersensitive and in which the treatment is well understood. It also includes a large group of patients who show similar nasal symptoms throughout the year or at times not coinciding with the pollenation period of grasses or weeds and who form a clinical group presenting problems which justify their separate consideration. It is to these perennial or non-seasonal cases that the term vasomotor rhinitis is usually applied and it is with this group that the present paper is concerned.

A survey of the large number of clinically proven cases of vasomotor rhinitis reported in the literature shows that about 60% of them are due to contact by inhalation or ingestion with some foreign substance to which the individual is hypersensitive. In the remaining 40%, the same pathologic picture and clinical symptoms may be produced by mechanical deformity in the nose, by infections in the nose or paranasal sinuses or by focal infection or metabolic disturbance elsewhere in the body. From this wide variety of possible etiologic factors it is certain that vasomotor rhinitis cannot be considered a purely rhinologic problem, and the allergist realizes that not all of them are due to hypersensitivity to foreign substances. The rational treatment must be designed to meet the etiologic factor or fac-

tors in each case if permanent relief is to be secured for the patient.

With a view to developing a plan which would most quickly and thoroughly determine the probable causative factors in any case of vasomotor rhinitis, 25 patients with this disease, mostly from the allergy clinics of the Newark Eye and Ear Infirmary and the Presbyterian Hospital, have been studied. Each case was investigated by history, physical and laboratory examinations and sensitization tests, in an effort to bring out the essential facts which, when summarized, would lead to a probable conclusion of extrinsic or hypersensitive etiology on the one hand, or of intrinsic or infectious cause on the other.

The history in a case of vasomotor rhinitis may develop strongly presumptive evidence of a hypersensitive etiology. While only 3% of individuals whose pedigree is free from all allergic manifestations as asthma, hay fever, migraine, urticaria, etc., will develop an allergic disease. 20% of persons in whose family tree there is allergic disease in one branch, will themselves suffer some hypersensitive disturbance; while over 50% of those with allergic diseases on both sides of the family will show some allergic manifestations and will develop them at a relatively earlier age. Therefore, we should regard with suspicion chronic or recurrent nasal symptoms in a patient whose pedigree shows a number of allergic individuals. As the manifestations of hypersensitivity are often multiple and frequently of changing type, the personal history should include a careful inquiry regarding significant symptoms such as eczema in infancy, food intolerancies and dislikes, and recurrent non-febrile colds. These symptoms often indicate an allergic constitution in a patient.

Because one-third of the cases of vasomotor rhinitis are of intrinsic cause and because intrinsic factors play a secondary part in many of the truly allergic cases, each patient should receive a thorough physical examination. In the general examination, a careful search for any and all possible foci of infection should be made, and note should be taken of all signs indicating the state of general health and metabolism. The condition of the skin, hair, nails and the presences of slight degrees of

edema are frequently significant, as these may give an important clue to an associated endocrine dysfunction. Symptomatically, primary attention is directed to the nose, and the nasal and sinus examination should be very thorough. It should be done by a rhinologist whose experience and point of view will be of value in the initial examination and also in the periodic follow-up examinations necessary in these cases. A bit of caution will be necessary in interpreting the clinical findings which will result from this special examination, as, by the use of modern methods, apparent pathology is demonstrated in the nose and sinuses of normal controls almost as frequently as in patients with nasal allergy. The rhinologist's findings should be interpreted in conjunction with the evidence obtained in the other lines of investigation.

The laboratory study of patients with vasomotor rhinitis should include those tests which will give positive or negative information regarding the varied etiologic factors recognized as capable of producing this disease. Of these tests, examination of the nasal secretions is the most important. The significance of eosinophiles in the nasal secretions of patients with allergic rhinitis was first reported by Eyermann in 1927 and his findings have been uniformly corroborated by subsequent reports from other investigators.

This type of cell is practically a constant finding in 5% to 80% of hypersensitive cases and is seldom found in infectious rhinitis. The test is so easy to perform and gives such definite information that rhinologists should make use of it more often as a step in determining the course of investigation and treatment to be followed.

Eosinophilia in the blood, when present, gives positive evidence to support a diagnosis of hypersensitive etiology but it is so inconstant in clinically proven allergic cases that its absence has no value in ruling out such cause.

In my study, the laboratory tests chosen to indicate the presence of infection were the differential leukocyte count, with attention to the number of band or non-filament cells as enumerated in the Schilling index; and the blood sedimentation test. The value of both of these tests in suppurative lesions has been

given a great deal of attention. They supplement each other in giving information indicating systemic absorption from foci of infection. It should be emphasized that the relatively slight, yet definite, changes seen in both of these tests in chronic focal infection are of important significance.

Anemia, gastric achylia and hypothyroidism have been reported as particular conditions frequently associated with allergic as well as non-allergic diseases. The laboratory information which will show up these functional or metabolic disorders will be found helpful and often essential in arranging a therapeutic program.

Studies of the basal metabolic rate in allergic diseases have been decidedly few and somewhat controversial. In vasomotor rhinitis probably less than 50 reported cases have been investigated by this method. This is true in spite of the fact that the association of endocrine dysfunction with allergy has been suggested frequently and that thyroid gland and iodine therapy have been reported as effective agents in the treatment of this disease. Novak in 1927 reported 20 cases of vasomotor rhinitis, showing basal metabolic rates varying from zero to minus 22%, all of which were improved or cured by thyroid therapy. From this he concluded that vasomotor rhinitis was a type of thyroid myxedema localized in the nasal mucosa. I have determined the basal metabolic rates of 18 unselected patients with vasomotor rhinitis with very interesting results. The rates varied from plus 13% to minus 39%. Eleven or 61% were below the normal average of zero and 7 or 38% were minus 10% or lower. Those patients with the low basal metabolic rate generally showed other evidences of thyroid deficiency in the form of overweight, coarse hair, dry skin, slight edema, low blood pressure, etc. There appeared to be no significant relation between the low metabolic rate and the incidence of hypersensitive or non-sensitive etiology. However, 3 of the non-sensitive cases secured fairly prompt relief from thyroid gland therapy alone. It would be very interesting to know the metabolic rate of those patients who have been reported cured by the injection of free iodine.

Bacteria are important either as primary or secondary etiologic factors in many cases of vasomotor rhinitis. The relief given to patients by the use of autogenous or stock vaccines has been reported often. There is no doubt that a properly selected and prepared autogenous vaccine should be the most efficient therapeutic agent where bacterial allergy or secondary infection exists. The routine described here has been found very satisfactory in the management of this part of the investigation. Swab specimens from the nares are mixed with 5 cc. of the patient's blood and from this mixture blood agar plates are prepared. These plates show well-isolated colonies of the various types of bacteria present and 1% suspensions of these are made for intradermal testing. Those bacteria which produce reactions are used in preparing the autogenous vaccine.

Another method by which these cases should be investigated is peculiarly and particularly in the domain of the allergist. I refer to the skin or sensitization tests. In the purest types of hypersensitivity there are in the blood, substances known as reagins which react specifically to the foreign substance to which the individual is sensitized. The cells of the deeper layers of the skin also react by wheal formation or by erythema, or both, when they come in contact with the offending foreign substance. The skin cells of a non-allergic individual may be temporarily sensitized to this substance by the intradermal injection of some of the patient's blood serum. Therefore, it is possible to prove by skin tests, hypersensitivity to a substance in many instances. Unfortunately, the skin reactions are often modified by infection, altered body chemistry or other causes and much experience is necessary to interpret the results of skin tests. All of the various reasons for false positive and negative reactions cannot be thoroughly explained in a paper of this nature. The number of substances which by inhalation, indigestion or injection have been the clinically-proven cause for vasomotor rhinitis is so large that it would be a too great, if not impossible, task to skin-test an individual with all of the substances with which he might come in contact. As a substitute we routinely test the pa-

tient with from 50 to 100 of the substances which have been most frequently found to be causes of allergic diseases, and which from the history are found to be present in the individual's environment and diet. This preliminary sensitization survey is supplemented by tests, using samples of the patient's pillow stuffing, house dust, etc. In this way the allergic factors in about 60% of the hypersensitive cases are detected. A more complete skin test should be carried out if other evidence points to an allergic etiology. The value of this is demonstrated by Rowe who finds after using about 500 substances that about 95% of his proven hypersensitive cases give positive skin reactions. Sensitization tests form the broadest foundation upon which a program can be most readily started in the allergic patient. They constitute only one part of an allergic investigation and it should be strongly emphasized that a report of 30 or 50 or more negative skin tests does not prove a person to be non-allergic.

A summary of the evidence obtained in each of the suggested lines of investigation should lead one to the logical conclusion of probable extrinsic or intrinsic etiology. In mixed cases there may be differences of opinion as to which factors are primary and which are secondary but, of course, treatment will be directed toward all causes.

By directing treatment toward the causative factors early, we should obtain more prompt and more permanent relief to patients with vasomotor rhinitis. The allergic treatment for the hypersensitive patient consists of removing the offending substance from the environment or diet, or if this is impossible, of increasing the tolerance of the patient to the substance by injections of gradually increasing doses of an extract of it.

The allergist's point of view in regard to the nasal treatment varies to some degree, depending on the allergist. However, certain principles seem to be agreed to by most of them. Mechanical obstruction by polyps or bad deflection of the septum should be corrected early. As the object of treatment is to restore the nose to as near normal condition as

possible, most allergists believe that conservative treatment of the turbinates and sinuses should be continued until the patient is brought under as good allergic control as possible. In this way the acute and edematous reactions to the infection are allowed to become quiescent and the exact limits of the chronic infected tissue to become demarcated. This means that a more complete eradication of the infection can be accomplished, and at the same time more functioning tissue in the nose can be retained, than if operation were performed in the beginning.

I have endeavored to show that the allergist regards vasomotor rhinitis as a disease which may be produced by a wide variety of causes and to suggest that treatment directed toward etiologic factors will be more uniformly successful. A plan of investigation has been suggested which, it is believed, will differentiate these cases into groups based on these etiologic factors.

DISCUSSION.

Dr. Alfred Mamlet (Newark): As rhinologists, we ought to be thankful to Dr. Brown for bringing forth a theory that really is a theory no longer, of susceptibility of individuals to allergy due to systematic conditions. There is no doubt that the rhinologist is puzzled very often in making diagnoses of cases that come into the office or the clinic. At this present stage we don't see how we are able to treat these cases unless we cooperate with the allergist.

In our clinics, all of us have to separate the cases of nasal disease into cases due to infection or nasal deformities or those due to allergic manifestations. The most difficult cases are those where we know that the cause of the vasomotor rhinitis is due to allergic factors but which, in skin testing, show reaction to almost any test. These cases are the most difficult to handle.

The point about injecting blood into another individual has been tried. A newer method has been advanced by Dr. Erskine of the Brooklyn Navy Yard, where he has been extracting foreign protein substance in the urine of the patient who is allergic but which is not found in patients not allergic. While his results are not 100%, he is leading us toward a successful way of treating some cases of vasomotor rhinitis.

As rhinologists, if we learn nothing else from Dr. Brown's paper, we should learn one thing: We simply must get the help of the allergist in the treatment of these very persistent vasomotor rhinitis cases.

ULCEROMEMBRANOUS STOMATITIS

FREDERIC W. LATHROP, M.D., F.A.A.P.,
Plainfield, N. J.

Ulceromembranous stomatitis occurs in two distinct forms, (a) as a mild chronic irritation of the gums and (b) as an acute fulminating stomatitis. In its acute form it has been known since the war as Trench Mouth. The disease is no respecter of person or social status, occurring when least expected in the best of private practice patients as well as in the dispensary type of patient.* In my own practice, I have found acute ulceromembranous stomatitis in approximately 2% of a series of 1800 patients. My interest in this condition was aroused when I tried to find the source of infection in several cases of trench mouth. I took smears from the gums of adult members of the families and received reports from the laboratory as positive for Vincent's organism in several cases. It was somewhat embarrassing when these people were told by their dentists that they most certainly did not have trench mouth. I decided it might be interesting to know how prevalent the organism is in so-called normal mouths of children.

There is a very considerable amount of literature concerning the pathologic importance of the fusospirillum of Plaut-Vincent. In frank cases of ulceromembranous stomatitis, Vincent's organism is always present in great numbers; no other organism is so constantly present. The characteristic organism has also been found in other lesions, particularly angina, osteomyelitis of the maxilla, lung abscess, bronchiectasis, and even in an infected finger which had been bitten by a man with trench mouth. Vincent first described the organism in 1896 in association with gangrene of putrefying wounds. It has been the feeling of most investigators that the fusospirillum is a secondary invader, only attacking tissues that have been devitalized by pyogenic organisms or whose resistance has been weakened by some other agency. The organism is very widely prevalent in the mouths of appar-

ently healthy adults. Baker found the fusospirillum associated with diseased teeth in 90% of the cases he examined, and Pilot and Brams found it in 82 of 100 tonsils examined routinely.

I have made smears from the gums of 100 children chosen at random in private office practice. In 26 of these the typical organism was found and in 15 other cases, large numbers of fusiform bacilli but no spirilla. This gives a total of 41 positive or suspicious smears from the 100 children. Two of the positive smears occurred in clinical cases of stomatitis. The other positive cases showed varying degrees of gum irritation around one or more carious teeth or else presented a deposit of tartar or detritus on the teeth. In none were the gums and teeth perfectly clean and normal, although many showed what would be considered merely an average amount of tartar. The number of organisms in the smears seemed to bear a closer relation to the care with which the smear was made than to the degree of inflammation present. A smear taken carefully, with considerable pressure on the gum margins, from a patient with simple tartar often was loaded with organisms equal to a smear taken lightly from the membranes in a clinical case of stomatitis. The spirilla did seem more numerous in the presence of definite inflammation. It soon became clear that a laboratory diagnosis of Vincent's stomatitis is practically of no value. We can rely more definitely on the clinical appearance of the gums than we can on the laboratory examination of a gingival smear. I did not find the organism in smears taken from 5 infants with no teeth. This is in agreement with the clinical fact that Vincent's stomatitis does not occur in infants before the eruption of the teeth.

The Vincent organism, then, is carried in the debris of many so-called normal mouths of children as well as adults. It multiplies in the presence of detritus or uncleanness of the teeth or gums, and actually invades the tissues when, for any reason, the local resistance

*Read at the Annual Meeting of The Medical Society of New Jersey, June, 1933.

of the mucous membranes becomes undermined.

There seem to be 2 distinct types of infection produced by this ordinarily harmless fusospirillum. They are produced either alone or in combination with pyogenic organisms. The first is a chronic gingivitis, commonly seen about a carious or dead tooth, and limited to the gum margins in the immediate vicinity of the diseased tooth. The other type is an acute stomatitis in which the infection spreads widely over the gums, involving often the tongue and tonsils, and the mucous membrane of the mouth. The importance of the chronic lesion lies in the danger of harboring a focus of fusospirilla in the mouth. One never knows when this focus may light up and cause an acute stomatitis. Such a focus may well be the source of the fusospirilla found in lung abscess and bronchiectasis. Vincent's stomatitis certainly is much more common in dirty neglected mouths than in mouths where the teeth and gums are kept clean and healthy.

There are several exciting causes which may precipitate an acute attack of Vincent's stomatitis. The first exciting cause, and the most important because it is most easily prevented, is trauma. The stomatitis is frequently brought on by extraction of a tooth, by injury of the gums, or by undue roughness in dental cleaning of teeth and gums. It frequently accompanies and increases the severity of a stomatitis due to mercury, bismuth, or scurvy. Again, we have the so-called trench mouth, when the disease apparently develops as an infection from without and frequently appears as an epidemic. It is very probable in these cases that the organism has taken on temporarily an increased virulence and is able to attack gums that appear quite healthy before and after the attack. The membranous form of stomatitis frequently occurs in the course of a severe acute infection which is accompanied by the usual sordes in the mouth, and this may add considerably to the discomfort of the patient. Any condition which causes a congestion of the mucous membranes, such as the eruption of a tooth or one of the acute contagious diseases, particularly scarlet fever, measles or mumps, may cause a temporary spread of the Vincent's infection.

Vincent, back in 1896, recognized and described 2 forms of stomatitis particularly associated with the fusospirillum; one which is diphtheria-like with a fine, pearly-white false membrane and only superficial ulceration, and the other the ulcerative type, with a soft, gray, very foul membrane and ulceration with edema. The ulcerative form is much more severe and is more apt to follow trauma or to occur during an epidemic of trench mouth.

The symptoms, then, vary according to the type of disease present, yet are easily recognized if one looks for them. The chronic lesion shows redness and puffiness of the gum margins, most prominent between the teeth or around the base of a carious tooth. The puffy, inflamed gum is moderately tender, and the mucous membrane in the vicinity may have a fine, pearly membrane. In the course of an acute stomatitis, the picture is more dramatic. The gums over a large area become very red and inflamed. The mucous membrane of the mouth, particularly over the hard palate and gums, is exquisitely tender. There is a fairly extensive pearly-gray membrane on the surface of the gums and numerous superficial ulcerations. In the more severe cases the ulcerations become deeper and may involve the tonsils and result in a Vincent's angina. The more severe the case, the more varied the types of lesion which are present. The breath is very foul. There is complete refusal of food because of the pain in the mouth. The child often appears very hungry but cries with pain after the first mouthful and refuses further nourishment. There is fever and general malaise.

Lichtenberg, Werner and Lueck in a rather startling article have shown recently that this acute infection is naturally a self-limited disease, running a course of 4 to 7 days. They had the courage to refuse treatment of any kind to their patients, and to their surprise found that these untreated children recovered as quickly as did the patients who were treated vigorously.

Corroboration of their findings appears in the fact that the remedies proposed for this disease are legion. Each advocate of a particular form of treatment points proudly to the fact that his patients show dramatic recovery

by the third or fourth day after treatment has been started. Some of the remedies proposed are sodium perborate, hydrogen peroxide, copper sulphate, hexylresorcinol, metaphen, iodine, iodine in glycerin, trypanflavine, arsphenamine and bismuth. Personally I feel that best results are obtained by using alternately a solution of sodium perborate 4% and a solution of copper sulphate 2%. Alternate solutions are applied every hour, either by spraying with an atomizer or by painting with a toothpick swab. There are several aromatic preparations of sodium perborate which have a pleasant flavor. I have been forced to warn my patient not to expect material improvement for about 2 days after beginning treatment, promising them that, after that period, recovery would be prompt and complete.

In an experience limited to 31 cases, using copper sulphate, sodium perborate or metaphen solution 1-1000, the symptoms in every case cleared up entirely inside of a week. The fever and the pain in the gums disappeared within 2 or 3 days in almost every case. In 2 cases, arsphenamine was used intramuscularly; in 2 others, arsphenamine was used locally but, apparently, with no specific effect. The organisms disappeared from the gums within 2 or 3 weeks. If the stomatitis does not improve in a very few days, we may be sure there is some underlying cause, such as a local irritant or metabolic disorder which is responsible for the persistence of the infection. Such conditions might be dead or carious teeth, metal poisoning, scurvy, chronic tetany or some chronic debilitating disease. Occasionally, it is necessary to treat or remove the diseased teeth before the Vincent's infection can be entirely eradicated. It is not wise to treat the teeth during the acute stage of the disease.

In contrast to the very limited nature of the acute process, the chronic lesion shows no tendency to clear spontaneously, often lasting for weeks or even months unless treatment is persistently carried out. I have found sodium perborate and copper sulphate as effective in clearing up the chronic lesions as they are in the acute attack.

The important lesson to learn from Lichtenberg's work is that treatment in these chil-

dren must be gentle and need not be expensive. Salvarsan is not necessary in the average case, either locally or intramuscularly. The potent escharotics, chromic acid and iodine, certainly must not be used on these tender gums. Drastic local treatment is more apt to prolong the infection than it is to shorten its course. In an infection that may be self-limited, it is important to avoid trauma and to do nothing which might interfere with natural recovery of the patient.

The acute attack of trench mouth should be readily recognized and treated until it is cured. It is important to be on the watch for the small chronic lesions and cure them. By eradicating these apparently minor irritations most acute flare-ups of stomatitis in our patients can be prevented.

SUMMARY

(1) Smears taken from the gums of 100 essentially normal children in private practice were positive for the Vincent's organism in 26 cases and suspicious in 15 cases.

(2) The laboratory diagnosis of Vincent's infection, therefore, is of very little value.

(3) There are 2 types of infection in the mouth associated with the Vincent's organism: Acute stomatitis and chronic gingivitis.

(4) The acute stomatitis tends to run a self-limited course; the chronic gingivitis tends to persist.

(5) Gentleness and persistence are more important than thoroughness in treating both types. Trauma tends to increase the spread of Vincent's infection.

(6) Local applications of copper sulphate and of sodium perborate are adequate remedies in the vast majority of cases.

DISCUSSION

Dr. Allen G. Ireland (Trenton): Dr. Lathrop found 41% cases out of 100 children examined. You can imagine, then, with 875,000 school children in the public schools how this disease prevails.

In the last two years I have received more requests from school physicians for information about Vincent's infection than anything else. As Dr. Lathrop cited, this infection is apparently a "football" between the dentists and the physicians. Many physicians say it is a dental problem while other doctors say it is a medical problem.

At a recent committee meeting of the State Dental Society that I attended, it was thought to be purely a medical problem. It hasn't been settled and there is nothing we can do here today to settle

it. However, if there was a committee of this Society which could get together with the committee of 5 dentists as now exists for the State Dental Society, we might arrive at some basis that would be extremely helpful to all. The State Department of Health has taken a hand in it, hoping to bring about some common basis of understanding, but it is still "up in the air".

We find a great many cases among school children. Dr. Lathrop, do you think they bring it in from the outside, or is there much chance of transmission within the school?

Of course, all of our schools are equipped with drinking fountains. All of them are not ideal fountains by any manner of means but we take precautions in our lunch rooms in caring for silver, dishes, and so forth. Of course, children do pass pencils around and put them in their mouths. Have you any basis for answering this question: Do you think there is chance of infection in the schools?

Dr. Lathrop: I have no particular basis for answering the question as to its actual contagiousness. Certainly it does appear in epidemic form and at such times it is advisable to avoid contact between mouths as much as possible. As a rule we don't find more than one clinical case in a family. I have always felt that it is a contagious disease, transmissible through the media of pencils, drinking fountains and cups. Any child with

the acute infection should be kept from school until the acute condition has subsided.

Dr. Ireland: Do you care to answer this question: Should the school physician recommend to the parent that the child be taken to a physician or to a dentist?

Dr. Lathrop: That is a somewhat embarrassing question. I think the dentist is likely to be a little too drastic in treating this condition and that it is a disease of the mucous membranes rather than of the teeth.

Chairman Johnson: If you say the dentists declare it to be a medical disease, then, I think, most of the doctors are perfectly willing to accept it. Did you find the doctors unwilling to treat it?

Dr. Ireland: Some to whom I have talked thought it a dental problem. Whether that is due to ignorance of the disease itself or whether they feel that it comes from carious teeth and belongs in that class, I don't know.

Chairman Johnson: Undoubtedly it is important for the dentist and the physician to cooperate in cases where there is chronic irritation from the teeth; but where there is true infection without carious teeth, the physician certainly could treat them.

ENDOMETRIOMA: REPORT OF A CASE

L. L. LEONARD, M.D., F.A.C.S.,
Asbury Park, N. J.

Since 1921 much has been written concerning "Ectopic Endometrial Proliferations". Sampson, Cullen and Novak in this country have stimulated considerable interest in this now well-established, but somewhat infrequent, phenomenon. Its presence, however, is often overlooked by the general surgeon and a diagnosis of inflammatory disease made.

Even the pathologist may be in error, unless, as stated by Ewing, the clinical picture is used as a guide to its true nature.

The nomenclature has developed into a large and varied list. This, doubtless, has been due to many contentions as to the etiology and pathogenesis of this condition. There are at least 29 different terms used by different writers at the present time. However, the term Endometrioma seems to have been almost uni-

versally adopted in this country because, (1) it seems to be descriptive and indicative of its chief source, and, (2) there is some doubt as to whether it is really neoplastic or inflammatory, or a congenital anomaly.

Distribution. The chief sites for the appearance of these ectopic endometrial lesions are confined to the lower abdomen; none ever have appeared above the level of the umbilicus. The usual location is: in 1000 cases in the ovaries, tubes and uterine wall; 90 cases in the recto-vaginal septum; 80 cases in the intestines; 56 cases in laparotomy scars; 34 cases in the inguinal region; 30 cases in the umbilicus and 5 cases in the vesico-vaginal septum, as found in "Polster Series of Collected Cases".

Acute appendicitis has been the diagnosis in

some well-proven instances of endometriosis of that organ.

Many occurrences in the laparotomy scar have been reported as necessitating wide excision to prevent recurrence. It is stated that pelvic endometriosis occurs in 10% to 20% of pelvic operations in women from 30 years of age to the menopause. From these statistics it is believed that the condition is often overlooked.

Because of the tissue so unusually involved, it would seem interesting to report the following case referred to the writer by Dr. T—— for surgical treatment.

Past history: Miss S. V., aged 34, maid, of good physique, weight about 130 pounds. Family history not important. Frequent tonsillitis until 1924 when a tonsillectomy was performed. Otitis media in January, 1928. Menses at 14, regular, with some pain. In August, 1928, was operated upon at another hospital when an appendectomy and a Gillium suspension of the uterus, the latter for a retroversion, were done.

Present complaint. The patient states that for the past year she has noticed a swelling on the lower abdomen at either side of the incision made at the time of operation. This swelling has steadily increased in size and become very tender, especially to touch and during exercise. The first examination revealed a mass about 3 inches long, 1 inch in width and 1 inch in thickness, apparently subcutaneous in position, very tender, smooth and immovable. On vaginal examination it was apparent that some type of suspension had been done.

The condition was so annoying that she sought surgical relief and was consequently admitted to the hospital. In the meantime, the previous operative procedure had been verified by a letter which stated that a "round ligament suspension" was done, but did not de-

scribe the technic. From the position of the mass a preoperative diagnosis was made of a growth involving the round ligaments, following a Gillium type of suspension. The operation which was done proved this diagnosis to be correct.

Operation. Under gas-oxygen anesthesia, the lower third of the original incision, a low midline position, was opened, and the mass, well adherent to the rectus sheath, was mobilized. The mass was then sectioned free at either side to the point of exit through the abdominal wall of the round ligaments, clamped and both limbs of the ligament cut. This entirely liberated the growth.

Gross appearance. The mass was very black with a liquid center of very dark material, rather thick in consistency, but no odor and apparently sterile. It bore resemblance to a degenerative process with liquefaction necrosis; the mass made one think also of melanosis. As the writer had never encountered a condition of this type, data were sought from a large research bureau. After reviewing several thousand cases, nothing of a like character involving the round ligaments of Gillium suspensions were found to have been reported.

Pathology. The growth was submitted to the pathologist, who reported as follows: a saucer-shaped, flattened mass without capsule, 8 x 5 x 3 cm. It was firm and resembled fibrous tissue. When sectioned, there were a number of small cysts, some containing clear fluid, others hemorrhagic. The round ligament was attached to this mass.

Histology: The stroma was made up of loose fibrous tissue. There were a number of cysts lined with low cuboidal epithelial cells. There was nothing to indicate malignancy. These glands showed a striking resemblance to the glands in the endometrium.

Diagnosis: Endometrioma.

DISCUSSION OF DR. MACKINNEY'S AND DR. COLLINGS' PAPERS

BY CHARLES H. DE T. SHIVERS, M.D., F.A.C.S. (CORRECTED)

In the November issue of The Journal, two articles which were read at the last Annual Meeting of the Society were published, one on "Suprapubic Prostatectomy" by Dr. W. H. MacKinney and the other on "The Plight of the Prostatic" by Dr. C. W. Collings. The discussion of these two papers was printed also. The remarks of Dr. C. H. deT. Shivers, of Atlantic City were not revised by him before publication; he requests, therefore, that the corrected discussion be printed, as follows:

Dr. Mackinney has had the advantage of a very wide and varied experience, and, after all, we gain our real knowledge only through personal contact with these cases, so I feel sure we can take for gospel truth what he says.

Several years ago, I had the privilege of spending some time with Sir John Thompson Walker, in London. I was very enthusiastic over his technic, the one-stage operation, and especially the after-results.

Living in Atlantic City as I do, I have the opportunity of watching numerous cases that had been operated on elsewhere, by the so-called "blind method of prostatectomy", and in a fair percentage of these cases, the outlet between the vesical and prostatic cavity was not clear-cut. In other words, there was either a diaphragm of mucous membrane or a prostatic nodule left behind. This was responsible for persistent frequency and burning during urination. When this obstruction and source of infection was removed, the patient recovered.

Thompson Walker, following enucleation of the gland with the patient in the Trendelenburg position, introduces a special bladder retractor which is self-retaining. This gives one an excellent view of the vesical outlet and prostatic cavity and allows one to remove bits of prostatic tissue, nodules and tags of mucous membrane.

For a number of years I did the Thompson Walker operation exclusively because of the excellent functional results I obtained, but found in cases of poor risk, especially those suffering from cardiovascular disease, that the two-stage procedure was the safer. Since introducing this method, our mortality rate has dropped below the average level.

It is my habit, in doing the first stage, to strip the entire anterior wall of the bladder and bring out the drainage tube as high as possible in the bladder incision, and on through the abdominal wall close to the upper margin of the wound. This makes the second stage very simple, as one merely has to remove the scar from the symphysis, to and including the sinus. There is plenty of room left on the anterior wall of the bladder to enlarge the inci-

sion and the prostate is removed without further disturbance to the surrounding tissue.

I was interested in hearing what Dr. Mackinney had to say about packing the prostatic bed. For a time it was my custom to do the same until, upon removing the packing from a case two days following prostatectomy, a severe hemorrhage developed and the patient died as a result. Since that time I have been introducing in all cases the Pilcher prostatic bag, and distending it only in those cases where there is hemorrhage at the time of enucleation or immediately after, or in patients that have a decided drop in their blood pressure during the operation. Our technic of introducing the bag is very simple, as we have *in situ* a No. 18 or No. 20 French Robinson catheter during the enucleation, after which the urethral portion of the bag is sutured to the tip of the catheter and the latter withdrawn, placing the bag in position in the prostatic cavity.

In removing the bag, which is done within 48 hours after the operation, Dr. Keyes has taught me a little trick which saves a lot of time and trouble. We suture the catheter that is to be introduced in the bladder for drainage to the urethral portion of the bag which is protruding from the meatus, after it has been carefully sterilized. As the bag is removed, the catheter is drawn into position for drainage.

Dr. Collings has done a lot for the advancement of transurethral prostatic surgery and certainly deserves plenty of credit.

Recently Dr. Mason and I had a man in the hospital with acute retention of urine which was due, we thought, entirely to an enlarged prostate. A catheter was inserted and the bladder gradually decompressed. At the same time this patient presented a large mass in the right scrotum and a diagnosis was made of irreducible hernia. At the operation Dr. Mason found necrotic bladder tissue in the hernial sac, which was extraperitoneal. This was removed and the patient made an uneventful recovery. He was then transferred from the surgical service to the urological service for the removal of a mechanical obstruction at the vesical outlet. Cystoscopic study showed a marked intravesical intrusion of the median and one lateral lobe. Prostatic resection was attempted because the patient appeared to be a poor risk for further major surgical procedure. After removing three or four pieces of tissue from the left lateral and median lobes, he developed a severe hemorrhage which was controlled with considerable difficulty. A large-size catheter was inserted into the bladder and the patient sent back to the ward.

After four days this was removed but the patient was unable to void so it necessitated reinsertion of the catheter. Three weeks after continuous catheter drainage, he had improved so that I decided to do a two-stage prostatectomy, from which he fully recovered.

As Dr. Mackinney has pointed out, it is extremely important to give careful attention to those cases that are in the process of preparation for prostatectomy. I agree with him that the operation is certainly not an emergency procedure. The same thing holds good in those cases that are to be resected. In other words, just as much care in the preoperative preparation should be taken as in those that are to be prostatectomized.

We have had excellent results with our transurethral prostatic resections. We have not lost a case. However, we have been careful in our selection, only operating on those patients that were considered suitable for this procedure. It is very

important after the operation of resection not to traumatize the deep urethra for at least a period of four weeks because I have seen ulcerations persist for two months. The danger of bacteremia in these cases following instrumentation is certainly a fact.

In closing my discussion, I wish to state that we do not consider the operation of transurethral prostatic resection entirely a minor procedure, and certainly not an office one. It should be done by a surgeon who is thoroughly familiar with the anatomy and pathology of the deep urethra and bladder outlet. He should also be capable of doing major surgery in cases of emergency.

A REQUEST FROM THE SECRETARY OF THE SOCIETY

Dr. J. B. Morrison, Secretary of our State Society, is preparing a list of medical families in New Jersey, where two or more generations or two or more members in one family have been engaged in the practice of medicine. This material will be stored away in the archives of a Medical History Club to which Dr. Morrison belongs, so that any historian in the future, who carries the history of medicine in New Jersey on beyond the point where we will stop in our outcoming History, may

have these data, given by the living descendants, and thus authoritative, at his command.

Letters have been written to the known members of such families, asking for this information, whether the linear descent was direct or not, and whether the members practiced in New Jersey or not. They are also requested to add any other medical history of import.

Those physicians who are interested, or who have such information, will kindly send the following data to Dr. Morrison, 66 Milford Avenue, Newark, N. J.

Name

Born at Date

Died at Date

Graduated from University or College of
Date

Practiced in for Years

Practice limited to

Medical Honors or Appointments

Civil Honors or Appointments

Served in Civil, Spanish-American or World War
Rank

Any other medical history of import
.....

Special Meeting

ON E. R. A.—MEDICAL RELIEF PROGRAM

A special meeting of the Medical Relief Advisory Committee of the State Medical Society and the Essex County Society was held at the Academy of Medicine in Newark on the afternoon of December 19. The present status of medical relief for indigents as it relates to the project sponsored by the Medical Society of New Jersey and the State Director of the Emergency Relief Administration, was the major subject for discussion. This project is being conducted in accordance with principles and policies mutually agreed upon, and which have been announced to each County Medical Society.

Those present were: From the E. R. A., Colonel Bigley and Dr. Tooker; from the Essex County Medical Society, Drs. Barkhorn, Sprague, Hawkes, Farr, Ill, Warner and Wallhauser; from the State Medical Society, Drs. Beling, Schlichter, Green, Snedecor, Quigley, Eagleton and Wilkes (Secretary).

Dr. Snedecor, Chairman of the State Medical Relief Advisory Committee to E. R. A., presided.

The general project was discussed. The difficulties which are delaying more rapid extension of the work were analyzed and constructive suggestions offered to overcome them.

From the evidence, the coöperation shown by the physicians is a subject for congratulation to the State and local committees and to the medical profession itself. This organized effort is proof of the ability and willingness of the profession to develop and conduct any needed medical service.

Only one flagrant case of abuse of the agreement by a physician has been reported. This man was immediately debarred by his County Society from participating in the work for a period of 6 months.

The chief difficulties met have been in the large cities where the problem is complicated by the existence of free clinics and city-appointed physicians to treat the indigent.

Analysis of these matters is being made in order to provide practical working agreements for the emergency period.

In rural and suburban areas the progress is much more marked and rapid.

The Trenton and Newark situations were discussed and recommendations were sent to the State E. R. A. Director. President Quigley asks that the mutual agreement provisions

be complied with in each case and that the State Director of E. R. A. so instruct the local and county directors.

Discussions on the C. W. A. plans and C. W. S. plans followed. The medical society members were informed that each County Medical Society (through its Medical Relief Advisory Committee) will be consulted in developing the procedures to be used. Their professional opinions as to prevention and cure of illness and accidents in the workers under these projects are to be sought by the E. R. A. County Director to whom has been assigned the executive work in each county.

On the afternoon of December 22, a similar meeting is to be held in Newark at E. R. A. headquarters, to settle differences of opinion and reach working agreements for the conduct of medical relief of indigents in Essex County. On December 28, a similar meeting will be held in Trenton to discuss the Mercer County problem and endeavor to remove the difficulties met there.

"DAMAGED LIVES"

For the past few weeks a motion picture with the above title has been drawing large audiences to one of Boston's theatres. The picture represents a sincere effort to educate the public as to the dangers of acquiring syphilis—and incidentally gonorrhea—through promiscuous sexual relations, to make them aware of the terrible consequences if the disease is not adequately treated, and to assure them of the possibility of cure if the infected person places himself in the hands of a reputable physician.

In spite of the fact that the play is loaded with propaganda, it is not without merit as a dramatic production. The cast is excellent; the appeal to one's sympathy is great. There is nothing cheap or tawdry about the play. If the situation seems to be attended by a bit more hysteria than is warranted, we may excuse it on the score of dramatic license. The play is followed by a lecture which describes clearly and in a dignified manner the nature of syphilis and gonorrhea.

The picture carries the approval of the American and the Massachusetts Social Hygiene Associations. That there is public appreciation of such a presentation is evidenced by the size and respectful attention of the audiences that have filled the theatre night after night.

The education of the public, particularly its more youthful members, cannot fail to reduce to some degree careless exposure to infection,

and to arouse in those who may become infected a determination to continue treatment until a cure is reached. On the other hand, is the medical profession doing its best for these sufferers? "Clinics and Field Agency Relationships in Syphilis and Gonorrhea Clinics" (which appears in the *New England Journal*), leads us to believe that there is much room for improvement. As a result of her intensive work in Boston hospitals, the author finds numerous defects in our care of the syphilitics who apply for help. There is, for example, an average delay of six weeks between the first visit of the pregnant woman who has syphilis and the institution of treatment. After the baby is born, and the postpartum period is ended, many of the mothers fail to continue treatment. Children with congenital lues frequently drift from one clinic to another for years before proper treatment is begun; too frequently permanent, irreparable damage has been caused by the delay. More care is needed in the detection of disease in the other members of the families of patients with syphilis.

Mrs. Morris' criticisms are by no means entirely destructive. She offers a number of practical suggestions for the better functioning of syphilis clinics, particularly as regards their coöperation with other departments. Her "Clinics and Field Agency Relationships in Syphilis and Gonorrhea Clinics" well deserves a place in a medical journal, for the physician who looks only at the disease, who does not consider the patient both as a whole and as a unit in society, is not living up to his responsibilities.—*Editorial—The New England Journal of Medicine.*

State Health Department

AMEBIC DYSENTERY

J. Lynn Mahaffey, M.D., Director,
State Department of Health,
Trenton, N. J.

Amebic dysentery has suddenly been recognized as a public health problem in the Temperate Zone under conditions comparable with those in New Jersey. The recent experience in Chicago shows that the disease may appear as a local outbreak reaching epidemic proportions or, through the medium of carriers, it may become endemic.

In New Jersey, although the disease has been declared communicable and reportable since 1917, relatively few cases were reported and probably few were recognized until very recently. The existence of many cases in Chicago during the past few months, and the publicity resulting therefrom focused upon this disease the attention not only of

medical and public health agencies, but also of many citizens.

Announcement in November of an outbreak in Chicago among employees and patrons of several hotels and eating places in the city soon resulted in closer study of cases of illness in all parts of the country in persons who had visited that city during the past summer and had returned to their homes. From November 15 to December 15, reports were received at the office of the State Department of Health of 12 cases in New Jersey; 8 of the reported cases are in males, 4 in females. Age of patients ranges from 8 years to over 60 years. Apparently all of these cases were infected outside of New Jersey. One was a chronic case of several years' standing where the patient gives a history of treatment in various hospitals. Ten of the reported cases had been in Chicago prior to onset, 8 stopping at the same hotel at some time between June and October, although only 2 were guests at this hotel at the same time. The date of onset of the cases ranged from about July 1 to November 11. Granting that infection causing these cases was received in Chicago, and that the dates of onset of illness as obtained were approximately correct, the possible length of incubation periods in this group was from about 8 to 40 days, except in 1 instance. In this case the first symptoms of illness are reported to have been about 80 days after leaving Chicago.

Additional cases are coming to light, some being in persons who have been ill for some time but the true character of whose illness had not been recognized. Doubtless other cases have occurred which were not recognized. While the State Department of Health has no record of the names and addresses of persons from New Jersey who visited Chicago this summer, undoubtedly the actual number of such visitors from our State is large. In addition to infected persons now known, there are doubtless others in this group who have not been and will not be discovered. Assuming that some of these infected persons will continue to harbor and eliminate the causative agent of the disease, the possibility of cases occurring at any time and in any section of the State in future must be kept in mind. Doubtless all physicians who receive copies of *The Journal of the American Medical Association* have read with interest the articles appearing in the issue of November 18 regarding treatment and symptomatology in this disease.

As an aid in confirming clinical diagnosis, laboratory examination of stool specimens is of value. The laboratory of the State Department of Health is prepared to give such aid. The types of examination made are 3: (a) Direct microscopic examination of fecal material; (b) microscopic examination of stained smears from such specimens; and (c) microscopic examination of cultures from stool specimens. Whenever practical, it has been found advisable to try all 3 methods before a negative report of an examination is made. Negative findings in one method do not necessarily indicate that examination by other methods will also give negative results. Specimens should be as fresh as possible at the time of examination. For this reason

it is preferable that specimens be brought to the laboratory by messenger. If this procedure is impractical, specimens may be forwarded in containers regularly furnished for submitting specimens of discharges for examination for typhoid bacilli. If such containers be used for this purpose, however, it should be plainly stated on the blank accompanying the specimen that examination for amebae is desired.

Measures to prevent the spread of amebic dysentery are, of course, similar to preventive measures in other diseases in which the causative organism leaves the body through the intestinal tract such as in the bacillary type of dysentery and in typhoid and para-typhoid fevers. A patient with an acute attack should be segregated as far as practical from others.

Precautionary measures should be adopted to prevent infection being spread to others in the household, including use of separate towels, drinking glasses and toilet articles by the patient; sterilization of eating and drinking utensils after use by the patient, etc. Persons affected with the disease, as well as persons who come in contact with them at the home, should take no part in handling food or drink for public consumption.

Release of a patient from restrictive measures is based upon the subsidence of clinical symptoms and negative laboratory results of feces examinations. For persons not engaged in handling food or drink for the public, there should be secured at least 2 successive negative examinations of stool specimens. These specimens should be collected at least 1 week apart, after the acute symptoms no longer exist, treatment has been discontinued and the stools have become normal in appearance. At least 1 of these 2 release specimens should be examined at the State Laboratory of Hygiene or at a laboratory approved by the State Health Department.

For release of persons whose occupation involves the preparation or distribution of food or drink for the public, a third negative specimen is required and at least 2 of the 3 examinations should be at the State or at an approved laboratory. Subsequent specimens from such food handlers should also be submitted from time to time as a check to determine whether, after apparent recovery, the patient continues to be a carrier of the *Endameba histolytica*. Such carriers do exist in considerable proportion among recovered cases; of course, they should take no part in handling food or drink for public consumption until repeated examination of intestinal discharges indicate they may do so without endangering the public.

School Health Department

Division of Physical and Health Education,
State Department Public Instruction

Allen G. Ireland, M.D., Director

SCHOOL HEALTH PROCEDURES

INSPECTION OF SCHOOL PLANT

The inspection carries weight when definite instructions have been issued. It should be made while the plant is in use, and it should include ob-

servation of the staff at work. A report should be made to the building executive and to the administrative officer of the system. It should state the findings and the suggestions for such corrections as may be necessary. A regular form used for reporting purposes systematizes the procedure.

In general, the items included in the inspection are as follows:

General cleanliness

Cleanliness of cafeteria and kitchen, including refrigerators and storage closets

Condition of toilets, lavatories, urinals, wash basins

Presence of soap and towels

Cleanliness of windows

Condition of blackboards

Condition of locker and shower rooms

Heating, ventilation, temperature

Lighting

Drinking fountains or other facilities

CARE OF EMERGENCIES

Whether subject to emergency calls or not, the school physician should formulate for the school administration one or more procedures with appropriate instructions that will care for all types of emergencies that may occur at school. These plans should be in writing and placed in a prominent place in every building and administrative office. They should be read and interpreted to all teachers and clerks every year.

The responsibility of the school physician for emergencies is a matter for local decision. Modifying factors are the number of physicians available, the proximity of clinics or hospitals, and the opinion of the school physician himself.

As a rule, boards of education seem to consider it advisable as a measure of protection to require the school physician to respond personally to emergency calls. No good argument against this policy has been advanced. For the most part, protests have been mercenary in nature. It should be clearly understood, however, that regardless of this policy, any physician may be called if the nature of the emergency is serious and a physician living nearer to the school is available.

MENTAL HYGIENE AIDS

The National Committee for Mental Hygiene is located at 450 Seventh Avenue, New York City. Write for list of publications.

REPORTING CASES

The state laws require that all cases of certain diseases and all suspects excluded from school be reported to the local board of health. Although this duty may be performed by the principal or the teacher in a one-room school or by a delegated member of the School Health Department, the school physician should assume responsibility with regard to the method of reporting, promptness, and supervision of the whole plan.

PUBLICITY

The success of the school health program depends to no little extent upon public understanding. Without a knowledge of purposes and achievements,

school health activities may be vague and superfluous to many people. On the other hand, it can be taken for granted that parents and the public are vitally interested in child health problems. It is good policy, therefore, to utilize every available means whereby the community may be kept informed of the program and results.

Although the school nurse is usually delegated to be responsible for publicity, the physician should be on the alert to suggest items of importance which may serve to awaken interest or to hasten the adoption of a needed activity. It is equally essential that material and presentation be clear and not subject to misinterpretation and to that end publicity material of a medical nature should be submitted to the physician for approval.

Communications

FROM STATE BOARD OF PHARMACY

In the December issue of The Journal, there appeared an editorial by Dr. Fischelis, Secretary and Chief Chemist of the Board of Pharmacy, State of New Jersey, on the subject of Hypnotic Drug Regulations. It is desirable that every physician be familiar with these rules. Dr. Fischelis in a letter sends the following:

HYPNOTIC DRUG LAW REGULATIONS

REGULATIONS FOR THE ENFORCEMENT OF CHAPTER 279
P. L. 1933, A SUPPLEMENT TO THE PHARMACY ACT
REGULATING THE SALE OF BARBITAL AND OTHER
HYPNOTIC OR SOMNIFACIENT DRUGS

PREAMBLE

It is clearly the intent of Chapter 279 P. L. 1933 to regulate the dispensing of barbital and other hypnotic and somnifacient drugs in such a manner as to prevent their harmful effects. The medical profession appears to be convinced that these drugs have a tendency to become habit-forming and that their continued use results in an addiction which is difficult to overcome. The spirit of this law as well as its letter places upon physicians and pharmacists the responsibility to so restrict the dispensing of these drugs under any and all circumstances as to protect the public against the possibility of becoming addicted to their use. At the same time it is recognized that the legitimate use of these drugs may be most helpful therapeutically, where such use is indicated.

It will therefore be the policy of the Board of Pharmacy of the State of New Jersey, which is charged with the enforcement of this Act, to so interpret its provisions as to cause as little interference as possible with the legitimate prescribing and dispensing of barbital and other hypnotic and somnifacient drugs and at the same time prevent as far as possible the promiscuous and unlawful dispensing of such drugs. The good faith of the physician in prescribing and of the pharmacist in dispensing barbital and other hypnotic and somnifacient drugs must be depended upon to carry out the intent of this act.

REGULATION No. 1—SCOPE OF THE ACT

No barbital, barbituric acid, malonyl urea, or other compounds, derivatives or preparations thereof may be dispensed or sold at retail to any person except upon the prescription of a duly licensed physician, dentist or veterinarian.

No sulphonmethane (sulfonal), sulphonethylmethane (trional) or diethyl- sulphondiethylmethane (tetronal), carbromal, paraldehyde, chloral, chloral hydrate, chlorbutanol or any compounds, derivatives or preparations thereof may be dispensed or sold at retail to any person except upon the prescription of a duly licensed physician, dentist or veterinarian.

The names of compounds, derivatives and preparations of these drugs are listed in Regulation No. 8.

REGULATION No. 2—RENEWAL OF PRESCRIPTIONS

Prescriptions for barbital and/or any other hypnotic and somnifacient drugs as defined in Chapter 279 Laws of 1933 shall not be renewed if the physician, dentist or veterinarian prescribing these drugs has written upon the face of the prescription the words "not to be renewed" or words to that effect. If the prescription bears upon its face the printed words "not to be renewed" or words to that effect, such printed statement shall have the same force as the written statement of a physician, dentist or veterinarian.

The constant or very frequent renewal of prescriptions for the drugs regulated in Chapter 279 Laws of 1933, without the knowledge or consent of the physician, dentist or veterinarian writing the original prescription must be considered a violation of the spirit of the law. This regulation should not be interpreted to prohibit frequent renewal of prescriptions for barbital and/or other hypnotic and somnifacient drugs as defined in Chapter 279 P. L. 1933 if such prescriptions are known to be intended for persons afflicted with epilepsy and other nervous disorders requiring frequent use of such drugs. In all cases involving the renewal of prescriptions it is incumbent upon the pharmacist to determine that such renewals are requested in good faith and not for the purpose of evading the act.

REGULATION No. 3—FILING OF PRESCRIPTIONS

Prescriptions for barbital and/or other hypnotic and somnifacient drugs must be preserved by the pharmacist by filing the original in a file kept for that purpose. It is not necessary to keep a separate file of these prescriptions but they must be kept available for inspection either in a separate file or in the regular prescription file of the pharmacy. They should not be kept in the same file as narcotic prescriptions as provided under the Federal and State narcotic laws. The provisions of Sections 2 and 3 of Chapter 309 Laws of 1933 also apply to these prescriptions.

REGULATION No. 4—DEVIATIONS

Prescriptions calling for barbital and/or other hypnotic and somnifacient drugs must be compounded and filed as directed by the prescriber. All of the provisions of Section 4 Chapter 309 Laws of 1933 relating to the compounding and dispensing of prescriptions apply to prescriptions for barbital and/or other hypnotic and somnifacient drugs.

REGULATION No. 5—COMPOUNDING OF PRESCRIPTIONS

All prescriptions for barbital and/or other hypnotic and somnifacient drugs must be compounded by a registered pharmacist or under the supervi-

sion of a registered pharmacist, and the provisions of Section 1, Chapter 309, P. L. 1933 apply to the compounding of these prescriptions.

REGULATION No. 6—DISPENSING BY PHYSICIANS

It is provided in Chapter 279 P. L. 1933 that physicians, dentists or veterinarians may dispense barbital and/or any other hypnotic or somnifacient drug to their patients under their immediate supervision. However, the practitioner must keep a record of the date, the drug dispensed, the quantity dispensed and the name and address of the patient. Such records must be available for inspection when required.

REGULATION No. 7—SALES AT WHOLESALE AND TO PHYSICIANS

Sales of barbital and/or other hypnotic and somnifacient drugs by manufacturers to wholesalers, retailers or medical practitioners; by wholesalers to retailers or to medical practitioners, and by one retailer to another, when carried on in good faith and not for the purpose of evading the provisions of this act, are permitted without the use of a prescription. Invoices or bills of sale or equivalent records covering the sale of barbital and/or other hypnotic and somnifacient drugs from manufacturers to wholesalers, retailers or medical practitioners; from wholesalers to retailers or medical practitioners, or from one retailer to another, must be kept on file by manufacturers, wholesalers, retailers and medical practitioners for a period of at least five years and must be open to inspection.

Sales of barbital and/or other hypnotic and somnifacient drugs by retailers to physicians, dentists or veterinarians must be made on a prescription written by the medical practitioner for the drugs desired, and such prescriptions must be kept on file by the pharmacist in the same manner as other prescriptions under this act.

REGULATION No. 8—DRUGS AND PREPARATIONS REGULATED BY THIS ACT

The following drugs and preparations come within the requirements of Chapter 279 P. L. 1933 and can be dispensed only on physicians' prescriptions. This list is not necessarily complete and the absence from this list of any chemical, drug, compound, preparation, derivative or formula which comes within the scope of Chapter 279, Laws of 1933, is not to be construed as exempting the same from the provisions of the law. The list below must of necessity be subject to addition and change. It is provided principally as a guide. It is to be understood that where proprietary names or official titles or chemical names are mentioned, all compounds, preparations, derivatives and all dosage forms of the product are included. For example, the term barbital includes tablets, clixirs, powders, pills or any other dosage form of barbital and any compound or preparation containing barbital except compounds, mixtures or preparations intended to be used as a spray or a gargle or a liniment or in any other wise for external application only, subject to regulation No. 9.

TO BE DISPENSED ONLY ON PRESCRIPTIONS

Abasin.
Acetanilid-Salicylic Comp. No. 3 Tablets.
Acetyl-brom-diethyl-acetyl-carbamid.
Acid-Acetylsalicylic-Barbital.
Adalin.
Adalin-Luminal.
Allonal.

Allyl-isobutyl barbituric acid.
Allyl-isopropyl-barbituric acid.
Allyl-isopropyl-acetyl-carbamide.
Alurate.
Amidobarbital.
Amidopyrine & Barbital.
Amidopyrine & Phenobarbital.
Amidopyrine diethyl barbiturate.
Amidopyrol.
Amidotol.
Amifeine.
Amidos.
Amobar Tablets.
Am-Phen-Al Tablets.
Amytal.
Apex Toothache Drops.

Baramid.
Barbethylate.
Barbital-Phenobarbital.
Barbital.
Barbital & Sodium Bromide.
Barbital Compound.
Barbital-Hyoscyamus Comp.
Barbital-Sodium.
Barbital-Sumbul Comp.
Barbituric Acid.
Barbival Comp.
Barlupulin.
Bassiphen.
Bromanodyne.
Brom-allyl-butyl-barbituric acid.
Brom-allyl-isopropyl-barbituric acid.
Brom-diethyl-acetyl-carbamid.
Brom-diethyl-acetyl-urea.
Bromide & Chloral Comp.
Bromidia.
Bromidonna with Chloranos.
Bromionyl with Barbital.
Bromiphen.
Bromoabis Comp.
Bromo-Cannibis Compound.
Bromo-Chloral Comp.
Bromodine.
n-Butyl-Ethyl-Barbituric Acid.

Cafinal.
Calcium Ethyl-isopropyl-Barbiturate.
Cannabis Compound.
Cannabrome.
Carbromal.
Carrie's Toothache Drops.
Chloral.
Chloral and Bromide Mixture N. F.
Chloral & Zinc Comp.
Chloral Bromide Comp.
Chloral Comp.
Chloral Comp. with Potassium Bromide.
Chloral Glyccrolate.
Chloral Glyccrinated.
Chloral Hydrate.
Chloranos.
Chlorbutanol.
Chloretonc.
Cibalgine.
Cociphen.
Colamide.
Colic Remedy (Chamberlain).
Compound Cerebral Sedative Rx "B."
Comb. Tablet No. 280 and No. 281 (Boerleke & Runyon).
Cough Persist. Phenobarbital.
Cyclo-Hexenyl-Ethyl-Barbituric Acid.

Dial.
Di Bromin.

Di-Brom-Barbituric Acid.
 Di-Brom-Propyl-Diethyl-Barbituric Acid.
 Di-Allyl-Barbital.
 Di-Allyl-Barbituric Acid.
 Di-Ethyl-Barbituric Acid.
 Di-Ethyl-Isopropyl-Barbituric Acid.
 Di-Ethyl-Sulfon-Diethyl-Methane.
 Di-Ethyl-Sulfon-Di Methyl-Methane.
 Di-Ethyl-Sulfon-Methyl-Ethyl-Methane.
 Di-Ethyl-Malonyl-Urea.
 Diogenal.
 Dipropyl Barbituric Acid.
 Dormitol Compound.

Endo-Lepsey Capsules.
 Ephedrine and Amytal.
 Ethel-Cyclo-Hexenyl-Barbituric Acid.

Hypno-Bromic Compound.
 Hypnos.
 Hypnotic Compound.
 Hypnotone.

Insomnital.
 Ipral.
 Ipralidon.
 Iso-Amyl-Barbituric Acid.
 Iso-Amyl-Ethyl-Barbituric Acid.
 Iso-Propyl-Brom-Propenyl-Barbituric Acid.

Kres-Lumin.

Lumalgin.
 Lumiflora Comp.
 Luminal.
 Luminal-Sodium.
 Lumodrin.

Maloynl-Urea.
 Medinal.
 Methyl-Phenyl-Barbituric Acid.
 Mistura Chloralis et Potasii Bromidi Composita
 N. F.
 Mobenal.

Narkogen.
 Natrona Comp.
 Nausea F. Barbital.
 Neonol.
 Nenurokardiac.
 Neuroids.
 Neuronidia.
 Nitrobar.
 Noctal.
 Nu-Bar-Bel.

Ortal Sodium.

Paraldehyde.
 Pascanoids.
 Passiflora Comp.
 Passiphen.
 Pentonal.
 Peralga.
 Pernocton.
 Phenamidal.
 Phanoform.
 Phenobarbital.
 Phenobarbital & Bromides.
 Phenobarbital & Sodium Bicarbonate.
 Phenobarbital & Sodium Bromide.
 Pheobarbital & Sodium.
 Phenobarbital-Sodium.
 Phenobarb-Thyroid Comp.
 Phenolbarbidine.
 Phenyl-Ethyl-Barbituric Acid.

Phenyl-Ethyl-Malonyl-Urea.
 Phenyl-Ethyl-Malonyl-Urea-Sodium.
 Pine and Somnos Cordial.
 Propphenbane.
 Propphenal.
 Propphenal Comp.
 Propphenite.
 Propanal.
 Pyradol.
 Pyraminal.

Quinetherol.

Sandoptal.
 Sedormid.
 Sedative Compound.
 Sedative Elixir.
 Sodium-Amytal.
 Sodium Di-Ethyl-Barbiturate.
 Sodo-Benzylate Comp.
 Somnol Tablets.
 Somnifene.
 Somnopyrine.
 Somnos.
 Soneryl.
 Spasmodic Colic Remedy.
 Sulphonal.
 Sulphoethylmethane.
 Sulphonmethane.
 Sumbul Tablets.
 Suppositories No. 14 Pancreols.
 Syrbal Comp.

Tetronal.
 Theobromine-phenobarbital.
 Theominal.
 Thymephen.
 Toluphen.
 Trional.

Utros.

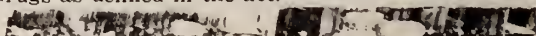
Valerian Comp.
 Val-Flower Comp.
 Veronal.
 Veronal-Sodium.
 Viburnum Comp.

Yersanco.

REGULATION No. 9--EXCEPTIONS

Chapter 279 P. L. 1933 does not apply to any compound or mixture or preparation of hypnotic drugs that is intended to be used as a spray or a gargle or a liniment or in any other wise for external application only; provided that such compound or mixture or preparation intended for external application only shall contain in addition to the content of barbital or other hypnotic or somnifacient drug, some other drug or drugs conferring upon it medicinal qualities other than those possessed by the barbital or other hypnotic or somnifacient drugs alone, and that such compounds or mixtures or preparations shall be sold in good faith for the purpose for which they are intended, and not for the purpose of evading the provisions of this act.

Solutions of drugs dispensed in ampuls, containing small amounts of chlorbutanol for preservative purposes are not considered as coming within the scope of this act, provided such solutions do not contain barbital or other hypnotic or somnifacient drugs as defined in the act.



PRESCRIPTION LAW REGULATIONS

REGULATIONS FOR THE ENFORCEMENT OF CHAPTER 309,
P. L. 1933, COVERING THE COMPOUNDING AND
DISPENSING OF PRESCRIPTIONS FOR DRUGS
AND MEDICINES

REGULATION No. 1—SCOPE OF THE ACT

This act is intended to restrict the compounding, filling, dispensing and selling of prescriptions of physicians, dentists and veterinarians to registered pharmacists or employees working under the immediate personal supervision of registered pharmacists. It is further intended to provide for the proper labeling and filing of prescriptions and for the prevention of adulteration and substitution.

REGULATION No. 2—APPRENTICE DEFINED

The term "apprentice" as used in this act shall mean an employee in a pharmacy who has been registered as an apprentice with the Board of Pharmacy by the owner of a pharmacy, if the owner is a registered pharmacist, or by the registered pharmacist manager in the case of a pharmacy not owned by a registered pharmacist.

REGULATION No. 3—PRESCRIPTION DEFINED

Prescriptions under this Act include written, verbal, telephonic or telegraphic orders for drugs and/or medicines, combinations or mixtures of drugs, and/or medicines, issued by physicians, dentists, veterinarians or other practitioners licensed to write prescriptions for the treatment or prevention of disease in man or animals. Prescriptions written and signed by medical practitioners enumerated in the law are considered "original" prescriptions. Prescriptions transmitted by medical practitioners enumerated in the law verbally or by telephonic, telegraphic or other means of communication must be recorded in writing by the pharmacist and the record so made constitutes an "original" prescription.

REGULATION No. 4—FILING PRESCRIPTIONS

Pharmacists compounding prescriptions must place the original prescription in a file kept for that purpose. Each prescription must be numbered and kept on file for a least five years.

REGULATION No. 5—LABELING PRESCRIPTIONS

Every prescription must be dispensed in a container bearing a label upon which must appear the name and address of the registered pharmacist owner or the name of registered pharmacist in charge if the store is not owned by a pharmacist or if it is owned by a corporation, the date on which the prescription was compounded, an identifying number under which the prescription is recorded in the pharmacist's file, the name of the medical practitioner writing or ordering the prescription, and directions for the use of the prescription by the patient as authorized by the medical practitioner. In cases where the prescriber has failed to include directions for use, the pharmacist should write on the label the words "use as directed".

REGULATION No. 6—ADULTERATION AND SUBSTITUTION

It is a violation of this Act to dispense more or less of any ingredient or the combined ingredients of a prescription ordered by the prescriber.

It is a violation of this Act if the finished prescription is found to contain ingredients other than those ordered by the prescriber.

The use of such inert ingredients as are required

in the art of compounding is permissible but such inert ingredients must not be used to replace the several or combined constituents ordered by the prescriber, without the prescriber's permission.

REGULATION No. 7—DEVIATIONS

The final weight or volume of a prescription must not be more or less than the original prescription calls for. The quantities of individual ingredients must not deviate from the weights or volumes prescribed. A reasonable tolerance may be permitted to account for manipulative procedures and normal variations due to unavoidable but harmless deterioration. Pharmacists will, however, be held to strict accountability for accurate weighing and measuring and for the use of drugs of standard strength as well as for strict accuracy in all operations involving subdivision of bulk quantities into the individual doses prescribed. "Eye measurements" in subdividing capsules, powders and similar dosage forms are not to be relied upon in place of accurate weighing and measuring devices.

REGULATION No. 8—SUPERVISION AND EQUIPMENT

Every pharmacy accepting prescriptions for compounding must be in charge of a registered pharmacist continuously and must be properly equipped with facilities, apparatus, utensils and stocks of drugs and medicines sufficient to permit the prompt and efficient compounding of prescriptions. The facilities, apparatus, utensils and stocks of drugs and medicines should include the following:

A clean, well ventilated room or space equipped with necessary laboratory tables with drawers and shelves; storage facilities and plumbing; poison cabinet; narcotic drug cabinet; facilities for heating, lighting, cooling and cleaning the premises; running water with facilities for heating and cooling; clean and sanitary surroundings; clean towels; facilities for sterilizing solutions and containers; a stock of U. S. P., N. F. and other commonly used chemicals, drugs and preparations, sufficient to compound ordinary prescriptions as dictated by experience in the community where the pharmacy is located; copies of the latest edition of the U. S. Pharmacopoeia, the latest edition of the National Formulary, the U. S. Dispensatory, New and Non-Official Remedies, and such other modern books on Pharmacy, Chemistry and Materia Medica as will enable the pharmacist to have ready access to information required in compounding prescriptions; compounding and manufacturing equipment, including tablet triturate molds, pill machine, pill tiles, ointment slabs, water bath, tripod, Bunsen burner, ring stand and rings, casseroles, evaporating dishes, percolators, sieves, test tubes, beakers, pipettes, graduates capable of accurately measuring volumes from one minim to at least one pint and from .1 cc. to at least 500 cc., glass mortars and pestles, Wedgewood mortars and pestles and porcelain mortars and pestles of assorted sizes, funnels, filter paper, steel spatulas and non-metallic spatulas of assorted sizes, glass rods, suppository molds or machine, empty capsules of various sizes, konseals, powder papers, clear glass and amber glass prescription bottles, eye dropper bottles, collapsible tubes, ointment jars, corks, labels; poison record book and narcotic record books; prescription files, numbering machine; thermometers for measuring temperatures from 0° to 250° C; scales and balances for bulk, medium and light weighing, at least one of which must be sensitive to 1/2 grain; apothecaries and avoirdupois weights from 1/2 grain to 1 lb.; metric weights from .020 gm. to 1 Kg.

County Society Reports

CAMDEN COUNTY

Vincent Del Duca, M.D., Reporter

The regular meeting of the Camden County Medical Society was held December 5, 1933, in the Camden City Dispensary Building, Camden. Dr. T. B. Lee, President, was in the chair.

The name of Dr. William Anderson, Haddonfield, was read as an applicant for membership; Dr. Harold K. Eynon, 579 Haddon Avenue, Collingswood, was unanimously elected to membership; Drs. Arthur Pratt and William T. Read took the oath of membership.

CANCER IN THE FEMALE PELVIS

The scientific program was a symposium on "Cancer in the Female Pelvis". Dr. C. F. Hadley read an interesting paper on its etiology and diagnosis. He discussed the mortality statistics with regard to the anatomical location of the lesions in the female pelvis.

Dr. Gordon F. West presented a paper which discussed the treatment. He divided the treatment regionally and discussed the operable cases and the use of radiation through radium and x-ray, with end results. The lower incidence of cancer of the cervix in those receiving proper postpartum care was stressed.

Dr. E. A. Y. Schellenger discussed the histology from a comparative normal and pathologic viewpoint. His paper was illustrated with microphotographic slides. At the conclusion of the papers, prior to the discussion, the essayists were accorded a vote of thanks by the Society. Discussion was opened by Dr. A. B. Davis who was followed by Drs. Lewis, Hessert, Shipman, Decker, McAlister and Lee. Dr. William Shafer, Vice-President, occupied the chair during the discussion given by Dr. Lee.

Committee Reports: Dr. T. K. Lewis, Chairman of the E. R. A. Advisory Committee, discussed the conduct of the Emergency Relief Program with relation to coöperation with the local E. R. A. This was discussed by Drs. Stone and Rogers.

Dr. E. G. Hummel, member of the State Public Health Committee, proposed that this Society appoint a Public Health Committee to coöperate with the State Committee. He was informed by the Chair that the Public Relations Committee heretofore had covered the field of public health problems. Discussion from the floor by Drs. Del Duca and Stone resulted in a motion to the effect that the President appoint a Public Health Committee for this Society consisting of 7 members and on which representation for the local Public Health, Public School and County Public Health organizations be provided.

The president appointed the following Public Health Committee, prior to adjournment, namely: Drs. Hummel, Stone, Collier, Lewis, Del Duca, Barrett and Pratt.

There were 58 doctors and guests present.

ESSEX COUNTY

Earl Le Roy Wood, M.D., Reporter

CANCER STUDY AND EXHIBIT

Essex County Medical Society observed Cancer Week by 3 days of exhibits and lectures on Cancer for both the medical profession and the public on December 5, 6 and 7, 1933, at the Academy of Medicine in Newark.

At a public meeting on the evening of December 5, Dr. Jonathan Wainwright, Past-President, American Society for Control of Cancer, and Chairman, Cancer Commission, Pennsylvania State Medical Society, advocated periodic health examinations as the most efficient means to combat cancer, on the basis that the best hope of a favorable result follows early detection and prompt, adequate treatment by surgery or radiation. Periodic examinations also should detect and lead to correction of the areas of chronic irritation where cancer so frequently develops subsequently.

Dr. Edward W. Sprague, President, Essex County Medical Society, opened the meeting. Dr. Henry B. Orton, Chairman of the Committee on Cancer Control, introduced the speakers. Dr. William H. Areson, of Upper Montclair, Past-President of the Essex County Society, spoke on the "Reasons for Cancer Control". Dr. Edgar A. Ill, read for his father, Dr. Edward J. Ill, State Chairman, American Society for Control of Cancer, a paper on "The Progress of Our Cancer Knowledge".

During 3 afternoons and 1 evening, brief talks pertinent to the exhibit were given at 15-minute intervals by some 50 local physicians who covered the subject in a most complete and capable manner. There were 17 exhibits by hospitals.

A fitting culmination of the 3-day cancer program was the evening meeting of the Essex County Medical Society on the last day. This was not a public meeting. Dr. Harrison S. Martland, Chief Medical Examiner, Essex County, and Associate Professor of Forensic Medicine, New York University, spoke on the topic "(a) Cause of Cancer—Present Status of Various Theories; (b) Metastasis". The address will long be remembered by every one present because the points were presented in the characteristic brilliant and inimitable style of the speaker. The fact that every seat in the large auditorium was filled with fully one-third more standing, was evidence not only of interest in the subject but of respect, affection and admiration for the speaker. It is hoped that the address can be published in *The Journal* as an original article at a future date. In honor of Dr. Martland, over 200 attended a dinner immediately preceding the meeting.

Favorable mention should be made of the educational pamphlets distributed at the meetings and supplied by the American Society for the Control of Cancer. These booklets gave in a brief, direct, understandable manner the salient facts about cancer for the guidance of all. They should be even more widely distributed.

The following valuable suggestions for the control of cancer printed on a single sheet of paper

were distributed and paid for by the Essex County Anatomical and Pathological Society:

**THE ESSEX COUNTY MEDICAL SOCIETY OFFERS
A FEW SUGGESTIONS FOR CONTROL OF CANCER**

(To Look and See Is Better Than to Wait and See)

(1) Be suspicious of any tumor anywhere, and any sore on the skin or mucous membrane that does not heal within two weeks. Be especially suspicious of any sore on the lip, or any wart or mole that is changing its character or size.

(2) Absence of pain in the tumor or sore does not mean absence of cancer. Almost all cancers are painless at the beginning.

(3) Cancer and tuberculosis may co-exist, and cancer frequently develops in syphilitic patients.

(4) The cause of any vaginal discharge must be determined. cervicitis commonly precedes cancer.

(5) Any irregular bleeding from the vagina, no matter how slight, should raise the question of cancer. Lugol's solution test may be useful in ruling out cancer.

(6) Bleeding from the uterus or vagina occurring after the menopause is likely to be due to cancer.

(7) Bloody urine is suggestive of cancer and its cause should be determined. An x-ray study and cystoscopic examination are usually necessary.

(8) Blood-stained stools, or bloody mucous, painful, frequent or difficult defecation, should lead to an immediate careful investigation of the rectum and bowel.

(9) Investigate the cause of any prolonged indigestion, especially after the age of 40. An x-ray examination is essential.

(10) Vomiting of blood is always a danger signal. Its cause must be determined.

(11) A complaint of bleeding piles often means cancer. Make at least a digital examination.

(12) The cause of difficulty in swallowing must always be investigated. This is best done by an x-ray examination or an oesophagoscopy.

(13) Any abnormal sensation persistently felt in the throat should be regarded seriously.

(14) The expectoration of blood without fever may mean cancer of the lung. Fever is commonly present late in cancer. Pain in the upper part of the chest, neck, or shoulder may be due to cancer. An x-ray study is essential.

(15) Be suspicious of hoarseness, not definitely due to a cold, or if continued more than two weeks. Careful examination of the larynx must be made.

While nothing really new was presented, the valuable restatement of established fundamentals is always helpful, especially in these days when publicity-seeking individuals release so many immature theories which divert attention from the few facts that are tried and true.

The general practitioners must continue to be the bulwark in the fight against cancer. There is little hope beyond his realm. It is mandatory that he be alert to detect the suspicious symptoms of early cancer and, when present, see that the patient is promptly and adequately treated. It is also his duty to detect and correct the chronic irri-

tations and precancerous conditions. He must investigate, visually and digitally, every orifice.

**The Academy of Medicine of Northern New Jersey
Section of Medicine and Pediatrics**

Benjamin Saslow, M.D., Secretary

The 168th meeting of the Section of Medicine and Pediatrics was held at the Academy of Medicine on December 12, 1933. The meeting was called to order by the Chairman, Dr. Polevski. The minutes of the previous meeting were read.

VERTIGO

The speaker of the evening was Dr. E. Spiegel, Professor of Experimental Neurology at Temple University, Philadelphia. His subject was "Vertigo".

Dr. Spiegel opened his talk with a perfunctory consideration of the physiologic effects of the stimulation and extirpation of the labyrinth. In both these procedures, a fall in blood pressure and a cerebral anemia occur. An increased muscular action of the intestines also results because of a reflex vagal stimulation. He next traced impulses from the vestibular branch of the eighth nerve as it enters the pons, and discussed the relationship of the basal nuclei of the medulla to the cerebellum and the third, fourth and sixth cranial nerves.

Dr. Spiegel demonstrated by many excellent slides, extirpation experiments upon different locations of the vestibule and brain. These experiments indicated vividly and clearly, the relationship of vertigo to injury to the labyrinth, cerebellum, the third, fourth, sixth and second nerves, the cerebrum, and various pontine nuclei.

Injury to the cerebellum causes a loss of muscular tone and of muscular coördination of the body.

The vestibular apparatus, Dr. Spiegel indicated, may be injured by fracture, tumors, leukemia, hemorrhage, syphilis, toxic neuritis and the infectious diseases. In an injury to the peripheral labyrinth, there results a subjective feeling of rotation of objects, with a nystagmus and a falling in the direction of the quick component of the nystagmus.

Vertigo, Dr. Spiegel stated, may result from a pathologic process in the centers previously described; but disease in a central location may be differentiated from disease in the peripheral labyrinth, as follows: With injury to the labyrinth, the nystagmus is in the direction of the normal side; with injury to the central nuclei, the nystagmus is away from the side of the injured nuclei.

Injury to the fourth, third and sixth nerves in the musculature of the eyeball will produce unsteadiness, because the afferent impulses from these nerves to the medullary centers, are interrupted.

Injury to the optic nerve, Dr. Spiegel pointed out, may cause vertigo, because of the close relationship of visual impulses from the retina to the medullary nuclei. In such a condition, the patient tends to fall in the direction of the slow component of the resulting nystagmus.

After a period, vertigo and nystagmus will decrease or disappear in vestibular injury because of the compensatory ability of other portions of the brain to take over the vestibular function, particularly when aided by the visual sense.

Next, Dr. Spiegel discussed the relationship of proprioceptive sense in muscles, joints, ligaments and skin to the maintenance of equilibrium, posture and vertigo.

Finally Dr. Spiegel described the Barany test, its modifications and limitations in labyrinthian and central nuclear disease.

The paper, which was most comprehensive and very clearly presented, was very well received.

After a short discussion by Drs. Beling, Barkhorn, Loeser, and Bergman, the meeting adjourned at 10.45 p. m.

Associated Physicians of Montclair and Vicinity

Edwin A. Seifert, M.D., Secretary

The regular meeting of the Associated Physicians of Montclair and Vicinity was held on November 24, 1933, in the Assembly Room of the Essex County Isolation Hospital at Belleville.

Dr. Charles McGinnis, the President, opened the meeting. Those elected to membership in the association included: Lewis W. Brown, M.D.; Aloysius Barry, D. D. S.; George R. Carty, D.D.S.; W. P. Shirreff, D.D.S.

The President recommended that resolutions of respect, in memory of Jesse Teed, D.D.S., whose death occurred during the month, be drawn up by the Executive Committee and sent to his family.

Dr. Elmer Johnson, of New York City, gave an interesting paper on "Anorexia in Children". Drs. Warren Ripley, W. S. MacDonald, O. A. Mockridge, Otto Leber, Frederick Von Hofe and Chester Brown discussed Dr. Johnson's paper.

The next regular meeting of the association will be held at the Essex County Isolation Hospital, Friday, December 15, 1933, when Murray A. Jenkins, L.L.D., Counsellor at Law, of New York City, will address the society on "Malpractice".

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The Gloucester County Medical Society held its regular monthly meeting at the Hotel Pitman on December 21, 1933.

Dr. David L. Farley, associate professor of clinical medicine at the University of Pennsylvania Medical School, addressed the members. He spoke on the classification of anemias and discussed some newer methods of treatment. An interesting discussion followed his address.

Dr. LeRoy A. Wilkes, of Trenton, Executive Secretary of The New Jersey Medical Society, was also a guest at the meeting.

The Public Health Committee presented an interesting report.

Dr. Louis Ruttenberg, of Mantua, was elected to membership.

Following the meeting the members of the Auxiliary joined the society at a buffet supper served in the hotel dining room.

Members present were: Drs. Ruttenberg, Dun-

can Campbell, William Brewer, H. B. Diverty, Fuller G. Sherman and Dorothy Rogers, of Woodbury; E. S. Black, Williamstown; T. M. Gairdner and C. I. Ulmer, Gibbstown; Don Weems, Wenonah; B. A. Livengood, Swedesboro; Frederick G. Wandell, Clayton; William Pedrick and Charles Pedrick, Glassboro; E. Z. Hillegass, Mantua; I. W. Knight, W. J. Burkett, Thomas Sooy and W. P. Chalfant, Pitman; Horace M. Fooder, Williamstown; Ralph K. Hollinshed and E. R. Ristine, Westville.

Visiting delegates were: Dr. O. R. Kline, Dr. A. G. Kinney and Dr. Patton, of Camden, and Dr. Muriel Ramsey, Millville.

HUDSON COUNTY

J. N. Connell, M.D., Reporter

The regular meeting of the Hudson County Medical Society was held on December 5, 1933. Members of the medical staff of Christ Hospital presented the scientific program, Dr. Street relinquishing the chair to Dr. Green.

A CASE OF MACROCYTIC ANEMIA OF UNUSUAL ORIGIN

By Dr. H. Von Deesten, Jersey City

Dr. Von Deesten presented a man, aged 40, whose present illness began 15 years ago (1919) while serving in the Navy, with attacks of anorexia, occasional vomiting, colicky pains and frequent watery stools. He was sent to a government hospital for 6 weeks. He was discharged without a definite diagnosis.

From 1920 to October, 1923, the pain attacks occurred periodically and a gradual enlargement of the abdomen was noted. In February, 1924, he consulted Dr. Von Deesten for the same attacks and the enlargement of the abdomen. Inspection disclosed emaciation and a patchy, brownish pigmentation of the face and neck. The skin was dry and scaly. The abdomen was much enlarged, and a fluid wave was apparently elicited.

Sigmoidoscopy revealed the mucosa of the rectum and sigmoid to be uniformly pale and vulnerable on contact, indicating an old colitis. There was no blood, pus, or excess mucus.

A diagnosis of tuberculous peritonitis with ascites was made, and the man was operated upon on March 17, 1924, under local anesthesia. Operation disclosed the adhesive type of tuberculous peritonitis. No free fluid was found in the abdominal cavity. There was no relief of symptoms.

The man was not seen by Dr. Von Deesten from that time until September 23, 1933, a period of almost 10 years. During this period he lost 40 pounds, but continued to work.

From 1929 to August 22, 1933, the same periodic attacks of diarrhea with gradual loss of weight and strength, persisted. On August 22, 1933, he had an attack of acute intestinal obstruction and was hospitalized. The obstruction was relieved with the aid of enemas, rectal tubes, irrigations, etc., and operation was refrained from.

A roentgenogram of the large intestine taken at

the hospital revealed marked distention of the colon. The man left the hospital 3 days after admission.

Because of weakness and edema of the legs since his last hospital admission, he again consulted Dr. Von Deesten. The following is a synopsis of the physical examination begun on September 23, 1933: (1) Emaciation; (2) weight 100 pounds; (3) brownish patchy discoloration of the skin; (4) edema of both feet; (5) *Achylia gastrica*; (6) tongue smooth and atrophic; (7) abdomen greatly enlarged. Inspection disclosed visible peristalsis with marked distention of the intestinal coils; (8) a roentgenogram of the chest was negative for pulmonary tuberculosis, but showed eventration of the left diaphragm with displacement of the heart, the latter probably due to distention of the gastrointestinal viscera and weakening of the dome of the diaphragm, consequent upon the chronic tuberculous peritonitis.

Because of the recent ileus, it was not deemed advisable to undertake a gastro-intestinal series for fear of producing obstruction.

The blood count on September 23, 1933, showed: Hemoglobin, 62%; red cells, 2,300,000; color index, 1.4; platelets, 40,000; white cells, 3600.

Differential count—Polymorphonuclears: segmented forms, 63; staff forms, 5. Basophiles, 1%; eosinophiles, 2%; lymphocytes, 23%; mononuclears, 3%; plasma cells, 1%.

Macrocytosis, anisocytosis and poikilocytosis present. No reticulocytes.

The plus color index, the low platelet count, the leukopenia and the presence of a macrocytosis is the classical blood picture of pernicious anemia.

The blood count taken on December 4 showed:

Hemoglobin, 90%; red cells, 3,700,000; color index, 1.2; platelets, 180,000; white cells, 4500.

Differential count—Polymorphonuclears: segmented forms, 53; staff forms, 10. Basophiles, 1%; lymphocytes, 3%; mononuclears, 3%.

This improvement in the hematologic findings followed after the man had been given a high caloric diet and liver in the form of capsules. The man's color and strength improved; the attacks of diarrhea still persisted.

In the number of cases reported by Meulengracht and others, it is felt that there is sufficient evidence to justify a diagnosis of stricture anemia. This anemia is probably due to a lack of, or failure of, absorption of some anti-anemic principle, as expounded by Castle, caused by a disturbance of the gastro-intestinal function.

SUMMARY

(1) A case of chronic dilatation of the gastro-intestinal viscera with stasis was reported, due to chronic tuberculous adhesive peritonitis.

(2) The blood picture (macrocytic anemia) is similar to that of intestinal stricture anemia, due to healed or partly healed tuberculous ulcers, and is indistinguishable from the blood picture of pernicious anemia.

(3) The administration of liver extract caused an amelioration of symptoms and a change in the blood picture toward normal.

(4) Chronic adhesive tuberculous peritonitis, to Dr. Von Deesten's knowledge, has not been mentioned as an etiological factor in stricture anemia.

DISCUSSION

Dr. Jaffin stated that he did not know whether to regard this as a case of tuberculous peritonitis with macrocytic anemia, or a case of pernicious anemia with peritonitis. He had never seen a case of tuberculous peritonitis with that blood picture.

Dr. Jaffin thought, too, that sprue should be considered.

Dr. Von Deesten said that blood counts of this patient had been taken 9 years ago, and no evidence of pernicious anemia was found.

Dr. Von Deesten did not say that the man had tuberculous ulcers in the intestines, but the case is similar to those cases of macrocytic anemia that have been due to healed or partly healed tuberculous ulcers in the intestines. If tuberculous ulcers, they seem to have been a rather mild form.

This patient has shown no pulmonary tuberculosis so far as is known. In every such case reported, no pulmonary tuberculosis was found, and this was confirmed by autopsy.

The case was also discussed by Dr. Alter.

THE PRESENT STATUS OF GOITER WORK

By Dr. Donald Miner, Jersey City

Last year at the Canadian meeting of the American Association for the Study of Goiter, a new classification was created by a committee appointed for that purpose. The classification made was as follows:

- (1) Non-toxic diffuse goiter.
- (2) Non-toxic nodular goiter.
- (3) Toxic diffuse goiter.
- (4) Toxic nodular goiter.
- (5) The thyroiditides.
- (6) The malignancies.

This classification has helped a great deal in simplifying goiter nomenclature, and I will talk to you for these few minutes on this classification excepting the inflammatory and malignant conditions.

(1) The non-toxic diffuse goiter is the endemic goiter which occurs in the goiter belts and which is present at birth or may develop in childhood. It also includes the adolescent goiter and simple goiter. In the endemic goiter the prophylactic use of iodine is advocated by Marine—2 grams of sodium iodine twice a day for 2 weeks twice a year—is extremely effective. Non-toxic diffuse goiters are rarely operated on, and then only for cosmetic reasons. The best treatment is considered to be to let the condition alone. Formerly, small doses of iodine were given but it has been found that prolonged iodine medication for adolescent and simple goiter frequently stimulate the simple goiter to toxicity.

(2) Non-toxic nodular goiters. These goiters are usually operated on only for cosmetic appearance or pressure of the substernal adenoma. However, because all malignancies originate in nodular goiters, there is a great question if these goiters should not be considered, as benign lumps in the

breast are considered, as the site of potential malignancy, and should be removed for that purpose, even when pressure and unsightliness do not exist. Goiter literature contains many references to the bad effects of iodine on these non-toxic nodular goiters, in that many of them are stirred into toxicity by iodine medication. It is considered that about 40% of non-toxic nodular goiters become toxic eventually, and it must be remembered that this toxicity is very subtle in its onset.

(3) Toxic diffuse goiter.—This type of goiter was formerly called exophthalmic goiter or hyperplastic goiter. It has a sudden, frequently explosive, onset, characterized by the well-known classic symptoms of tachycardia with overaction, tremor, heat intolerance, loss of weight with excessive appetite, muscular weakness particularly of the quadriceps group, and generally exophthalmus. In spite of a mortality rate of only 1%, a great number of these cases are treated medically with iodine. This is unfortunate, as a fairly large percentage develop iodine fixation and lose valuable time during which permanent damage is done to the myocardium and other organs. It is my opinion that if all of these cases were operated on the first few months of their illness, the death rate would be practically zero—in other words, I plead with you to consider these cases as definitely surgical as acute appendicitis, and to consider that the element of time is just as important in both.

Persistent post-operative exophthalmos is being given increasing attention by goiter men. Undoubtedly a satisfactory operative procedure on the eye will eventually be evolved to cure this objectionable condition which persists postoperatively in so many of our neglected cases. The procedures so far proposed have been directed toward removal of the indurated postorbital fat, and the results have been quite satisfactory.

Probably the most difficult condition to differentiate from exophthalmic goiter (toxic diffuse goiter) is neurocirculatory asthenia. Briefly, the differentiating points are as follows: cardiac overaction, excessive appetite, euphoria, increased basal metabolism, and quadriceps weakness are absent in neurocirculatory asthenia. Though both cases may have a tachycardia of the same amount, the heart behavior is quite different. Whereas the exophthalmic goiter patient will try to do the impossible when asked, the neurocirculatory asthenia patient will give up before trying. There are many other differentiating points, such as the differences in the type of tremor, which I will not cover at this time.

(4) Toxic nodular goiter is in many respects the most interesting, clinically, of the various types of goiter we see, and when accompanied by the thyrotoxic heart in the advanced stages, surgery offers most spectacular results. Credit must always be given to Dr. Frank Lahey for directing attention to the results that can be obtained by daring to operate on these apparently hopelessly-ill people. The operative mortality usually averages about 3% and is higher than any other type. All should be x-rayed for deviation of the trachea which is frequently the only sign of intrathoracic adenoma. I believe thor-

oughly in a very short preoperative course of iodine in these cases, for one cannot be sure that hyperplasia outside of the adenomas does not exist. In fact, this is found frequently enough to justify this medication as a routine procedure. Post-operative myxedema occurs most commonly after operation in this class of goiter.

SOME VAGARIES OF THE URINARY SYSTEM

By Dr. S. R. Woodruff, Jersey City

Dr. Woodruff first considered renal calculus. He stated that one thinks of renal calculus in terms of severe renal colic, hematuria, etc. As a matter of fact, this does not always occur. For many years, Dr. Woodruff has taught that the principal symptom of stone in the kidney is indigestion. The term renal colic may well be called a misnomer. What is called renal colic is usually ureteral colic, and is the condition present when the calculus, acting as a foreign body, irritates the ureteral mucosa and causes a spasmodic condition to exist there. A calculus resting quietly in the renal pelvis causes very few symptoms. Indigestion due to a reflex sympathetic irritation is the chief symptom.

When infection and erosion of the pelvic mucosa take place, the usual sign is a dull, boring, nearly constant backache, aggravated by standing or riding and particularly by violent exercise. Symptoms akin to lumbago are often noticed, and Dr. Woodruff cited the case of a woman who recently has been in bed for 3 weeks with a supposed attack of lumbago, that revealed by x-ray and cystoscopic check-up, a good-sized calculus situated in the lower calyx of one kidney. Her urine was clear, and microscopically contained only a few pus cells. Removal of the calculus cured the lumbago magically.

The absence of blood and pus in the urine certainly does not rule out renal or ureteral calculus, or even pyonephrosis, because in the latter condition the ureter may become sealed off by inflammatory exudate or adhesive bands, and intermittent pyuria results.

Dr. Woodruff stated that the frequency of enormous bilateral calculi is amazing. When the calculus enters the ureter, the picture immediately changes. A calculus lodged in the ureter usually sets up violent symptoms for 3 reasons: (1) The actual irritation of the foreign body to the nerve ends in the ureteral mucosa is as great as that caused by a cinder in the eye, and extreme pain results; (2) the rhythmical peristalsis of the ureteral musculature, which carries the urine downward into the bladder, is upset and painful spasm results; (3) the calculus immediately blocks the ureteral lumen completely and dams back the flow of urine, causing marked and exquisitely painful distention of the ureter and renal pelvis above it, with consequent absorption of toxic urine under pressure. This causes marked systemic symptoms such as chills, fever, nausea and vomiting.

All these symptoms may or may not be accompanied by hematuria. If the ureter is completely blocked, then the voided urine will be that from

the opposite kidney only, and no doubt will show no pathologic elements. This fact, Dr. Woodruff brought out, has confused many a diagnosis when an "acute abdomen" presented for treatment. Ureteral calculus may well cause sufficient symptoms to be placed in the category of "acute abdomen".

Dr. Woodruff here reiterated the statement that he made several years ago, that no acute abdomen should be opened until at least an x-ray has been taken and renal or ureteral calculus excluded.

Ureteral calculi may become chronic; that is to say, they may lie in the ureter for months or even years, giving rise to but few symptoms. They become more or less encysted in the ureteral lumen, dilatation takes place, and back pressure or obstruction are thus produced.

Ureteral disease and ureteral pathology, in Dr. Woodruff's opinion, are the cause of 90% of surgical renal lesions.

Hematuria, the most important of all urologic symptoms, is often the most neglected. One is apt to make light of a painless, intermittent hematuria that really hides important pathology, such as bladder tumor, renal neoplasm, or stone, but pay marked attention to a hematuria associated with vesical symptoms which may mean very little. Any hematuria should be studied and its source determined at once. Blood in the urine is always a grave symptom until otherwise determined.

The frequency of serious disease of the urinary tract without manifestations in the urine is astonishing. Calculus disease, renal tumor, and hydronephrosis are the most important examples. One makes a serious mistake who disregards a patient whose urine shows any pathologic elements in the presence of long-standing abdominal symptoms.

The similarity of symptoms between gall-bladder disease and right renal pathology is astounding. Calculus, hydronephrosis and pyonephrosis act very like cholecystitis, but are not difficult to differentiate. Hydronephrosis which suddenly becomes acute or strangulated due to ureteral torsion or angulation gives practically the same symptoms, such as severe pain, abdominal rigidity, elevation of temperature, nausea and vomiting. At the same time, there may be no pathologic elements in the urine.

Total anuria can be an ordinary nephritic condition, or can be caused by purely mechanical reasons due to calculus disease.

Bilateral renal disease is a fairly frequent occurrence. It is usually found in infected kidneys and may become two-fold in importance when an anomalous condition such as horseshoe or polycystic kidneys exists.

It is in bilateral infections that the importance of a painstaking urologic examination is apparent, for the removal of one infected kidney is rarely indicated, and if both kidneys are grossly affected, the result is swift and sure.

Dr. J. L. Rosenstein presented a case of Albers-Schonberg disease, which will be reported in the next issue of *The Journal*.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Secretary

ANNUAL BANQUET

The Mercer County Medical Society held its Annual Banquet at the Trenton Country Club on the evening of November 16, 1933.

The honored guest was Ex-Governor E. C. Stokes, who, with his accustomed equanimity, gave expression to many interesting and enlightening portions of history concerning several of our predecessors in the art of Medicine.

Dr. Frederic J. Quigley, President of the State Society, spoke with reference to the forthcoming work of the year.

Dr. J. Bennett Morrison, Secretary of the State Society, was also present.

About 90 members and their guests were present

ANNUAL MEETING

This meeting was held December 13, 1933, at the Carteret Club, Vice-President Dr. J. A. Connelly presiding. The minutes of the preceding meeting were read and approved. The Treasurer made his annual report, the Chair appointing Drs. Haggerty and Watts as an auditing committee, who reported the accounts in every way correct.

Dr. LeRoy A. Wilkes, Executive Secretary of the State Society, outlined the work of his office for the coming year, expressing the desire for consideration and cooperation.

Dr. A. E. Shipley, Editor of the State Journal, gave a short synopsis of the proposed policies of the State Society in the conduct of editing *The Journal*.

Dr. Wilbur Watts, Chairman of the E. R. A. Advisory Committee, made a verbal report of the several conferences of his committee, with the statement that certain recommendations had been determined, but in view of the forthcoming meeting of Committees relative to this important subject, these recommendations would be held in abeyance.

Dr. Watts also reviewed in detail several communications relative to the subject of a Physicians' Collection Exchange, explaining 2 systems submitted, that might be adapted to the Society.

The resignation of Dr. Arthur B. Light, Medical Director of the Lawrenceville School, was read and accepted.

The following applications were referred to the Membership Committee: Drs. R. T. Buckley, William Cohen, H. K. Doranz, G. F. Hutchinson, A. G. Ireland, J. F. Knstrup, William K. McCandliss, M. L. Poyas, B. B. Scasserra, I. P. Davenport, J. A. Tempesto, Samuel E. Watov and LeRoy A. Wilkes.

The following applicants were elected: Drs. A. J. Fessler, F. D. Hunter, W. R. Peterson, active members; Drs. J. J. Beller, H. L. Drezner, Max Friedman, F. M. Hammell, H. S. Urbaniak, M. R. Zentner, associate members.

The following officers were nominated and elected in due and regular form: President, Dr. John A. Connelly; Vice-President, Dr. R. J. Cottone; Sec-

retary-Reporter, Dr. A. D. Hutchinson; Treasurer, Dr. H. R. North; Censor, Dr. G. W. Williams; Member Nominating Committee, Dr. H. R. North; Member Nominating Committee, Alternate, Dr. D. L. Haggerty; State Delegate, Dr. F. E. Proctor; State Delegates, for 3 years, Dr. A. D. Hutchinson, Dr. H. R. North, Dr. J. S. Vanneman.

The President appointed the following membership committee: Dr. H. D. Bellis, Chairman; Dr. Charles F. Adams and Dr. Charles R. Sista. For the program committee: Dr. C. Walter Carroll, Chairman; Dr. C. C. Chianese and Dr. J. L. Wikoff.

The next meeting of the Society will be held on January 10, 1934.

MONMOUTH COUNTY

Robert A. MacKenzie, M.D., Reporter

NOVEMBER MEETING

The Monmouth County Medical Society held its monthly meeting at the Monmouth Memorial Hospital, Long Branch, on Wednesday evening, November 22, 1933.

After the regular business session the President, Dr. Robert E. Watkins, introduced Miss Evelyn T. Walker, Director of Public Health of the Monmouth County Organization for Social Service. Miss Walker spoke briefly concerning the policies which govern public health nurses in their relations with the medical profession. She referred to the increasing interest and leadership in public health affairs which the doctors in Monmouth County are taking and expressed the desire of the nurses to cooperate in every way possible in their care of private patients and in working out the problems of medical service under the State Emergency Relief Administration.

The Scientific program consisted in the presentation of a paper by Dr. William Francis Honan, Professor of Surgery, New York Homeopathic Medical College and Flower Hospital. The paper was entitled "The Indications and Surgical Technic for the Surgical Treatment of Pulmonary Tuberculosis" and was illustrated with a moving picture by Dr. Bonnard Teagarden, Clinical Assistant, Department of Surgery, New York Homeopathic Medical College and Flower Hospital.

DECEMBER MEETING

The Monmouth County Medical Society held its annual meeting including the election of officers in the American Hotel at Freehold, New Jersey, on the evening of December 12, 1933. About 40 members were present for dinner, following which the President, Dr. Robert E. Watkins, called the meeting to order. The elections to membership in the Society added the names of Dr. S. S. Ellenson, of Asbury Park, and Dr. Granville Barker Jones of the New Jersey State Hospital at Holmdel to the roll. The report of the nominating committee, Dr. William K. Campbell, Long Branch, Chairman, was called for and the nominations accepted and the nominees elected by unanimous vote as follows: President, John E. Maher, Long Branch; President-Elect, Warren H. Fairbanks, Freehold; Secretary-Treasurer, Daniel F. Featherston, Asbury

Park; Reporter, Samuel Edelson, Neptune. It was noted that changes in the By-Laws designated a president-elect instead of a vice-president, and that the offices of secretary and treasurer are combined.

Following the election, Dr. John Maher accepted the gavel and briefly expressed his gratification at being selected to head the Monmouth County Medical Society for the next year. He expressed his intention of outlining his policies and nominating his committees at the January meeting.

Dr. Maher then called upon Dr. Watkins, who presented a most interesting and comprehensive view of the work of the Society for the past year, making particular reference to the formulation of plans for medical care under the Emergency Relief Administration, and complimenting Dr. Nichols upon his efforts leading to the formation of the Monmouth County Health Service Committee. Dr. Watkins' speech was received with much acclaim. It was the feeling of all present that the Society embarks upon the New Year in a most encouraging spirit of cooperation and hopefulness.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A regular quarterly meeting of the Morris County Medical Society was held on December 14, 1933, at The New Jersey State Hospital at Grey-stone Park.

Invitations were sent to the Warren and Sussex County Societies and to the Summit Medical Society.

President Frost had the pleasure of presiding over an assemblage of approximately 100 physicians.

RECENT TRENDS IN INVESTIGATIONS OF ALLERGY AND IMMUNITY AND THEIR RELATION TO MEDICINE

The "high spot" of the evening was an address by Dr. Lay Martin, of Johns Hopkins Medical School, on the above subject.

Dr. Martin prefaced his address by saying that he brought up this intricate subject because of work done during the past 4 or 5 years, which, perhaps may turn our thoughts into different channels on the subjects of immunity and allergy. This may entirely change our reaction to or method of treatment of certain diseases. Reverting to the preliminary work done in the past, the speaker brought his subject up to the present, citing and explaining the enormous amount of laboratory work and experiments being done. Dr. Martin presented his subject in a manner that held the interest of his audience and stimulated considerable discussion and also questions which the speaker answered. Those taking part in the discussion were Drs. Larson, Young, Krauss, Hatch, Beaver, Pinckney, Mial and Galasso. Dr. Martin was accorded a hearty round of appreciation for his able presentation.

Routine business included the unanimous action to continue the annual dues at \$15; the favorable condition of the treasury influencing this action.

Dr. Sherman reported on the progress of the program for medical care of Emergency Relief clients. He stated that various and sudden changes

injected into the problem prevented a complete report being presented at this meeting. He indicated that it would be submitted at the next meeting and that it would require a whole evening and a 100% attendance to handle it.

President Frost announced the formation of clinical societies within the County Society and that during the year there would be 4 meetings at various hospitals to be directed by the various clinical groups. The first will be at Morristown Hospital on the evening of January 18; in addition, there will be 4 other meetings of the Society for which highly capable speakers have been arranged.

Mr. Blanksteen, of the Medical Society department of the National Casualty Company, was extended the privilege of the floor and explained the advantages of health and accident insurance under the medical group plan. He announced also the broadened scope of the protection so that at proportionate rates the physician of limited means could have protection as low as \$25 a week and those who desired could have as high as \$100 a week.

After adjournment of the formal meeting, refreshments were served and enjoyed in the hospital cafeteria.

OCEAN COUNTY

W. G. Hayden, M.D., Secretary

The Annual Meeting of the Ocean County Medical Society was held at Forked River, on Thursday, December 7, 1933.

The special business of the meeting was the election of officers for the ensuing year. These officers are: President, Abraham Goldstein; Vice-President, Alfred Woodhouse; Treasurer, Frank Brouwer; Secretary, W. G. Hayden; Reporter, Eugene Herbolner.

UNION COUNTY

Russell A. Shirrefs, M.D., Reporter

A sleet storm that frosted the windshields of automobiles, and slippery roads that imperilled drivers and cars alike, to some degree cut the attendance at the regular meeting of the Union County Medical Society held on the evening of December 13, 1933, at the Highland Club, Summit, N. J. The 60 members who did attend were amply rewarded by the program, the main feature of which was a symposium on Peptic Ulcer. The guest speakers were: Dr. Albert A. Berg, Surgeon to Mt. Sinai Hospital, N. Y.; Dr. Burrell B. Crohn, Gastro-Enterologist, and Dr. Samuel Goldfarb, Gastro-Radiologist to the same institution. Following their helpful talks, a general discussion followed.

A resolution of regret on the death of Dr. Samuel Korngut was passed and signed by Dr. Arthur Stern, Dr. George T. Banker and Dr. Harry Block. The resolution is as follows:

"The medical profession of Union County records with great sorrow the death of Dr. Samuel Korngut. If modesty and righteousness are still virtues, then a kind Providence had given them liberally to this man. Those of us who knew him well,

found in him a source of unusual wisdom, a serene philosophy of life, a great knowledge of the profession he chose as his life work. We are sure that the people to whom he was the physician, the healer, when sickness threatened their lives, will never forget his great interest, his sound judgment and his pleasant ways. We, too, mourn him with them."

The following physicians were elected to membership: Drs. Joseph Novello, Elizabeth; Winthrop Hall, Westfield; William Brown, Elizabeth; Paul Kreutz, Elizabeth; Norman Murray, Summit; Malcolm Edgar, Summit; Loren H. Crabtree, Elizabeth; Milton Lieberman, Elizabeth; William Wachter, Hillside; Samuel Berenson, Elizabeth; Joseph Lepree, Elizabeth; Paul Colonna, New York City.

At the conclusion of the meeting, a buffet luncheon was served and a social hour enjoyed.

Woman's Auxiliary

A LETTER FROM THE PRESIDENT

December, 1933.

Greetings to Auxiliary Members:

All the members of the Auxiliaries to the Medical Societies in New Jersey are invited to the luncheon and open meeting of the Woman's Auxiliary to The Medical Society of New Jersey, to be held in Trenton on Monday, January 8, 1934. A notice will soon be sent to the county auxiliaries announcing the time, place, and nominal charge to be made for the luncheon. Please ask your officers for further particulars and notify the committee in Trenton so they can provide for your entertainment.

Whatever the objects or line of endeavor, if we are sufficiently interested to notice them, we have many ideas or suggestions presented to help us carry on. Such is the case in Auxiliary work. In this letter I will pass on to you some suggestions which may be most helpful. Lack of space will not permit the enumeration of all that I have received.

First, I would emphasize the suggestion of Mrs. Blake, our National President, who recently quoted Mrs. Alice Ames Winters' advice to "Undertake less and accomplish more". I advise this in selecting any of the ideas presented for us in your county programs. Because of varying local conditions the counties naturally will differ widely in the work they select to do. After deciding upon suggestions which most appeal to you, consult with your advisory committee for approval and for guidance as to the best methods by which to accomplish the work.

Have a benefit for placing Hygeia in every school in the county. Any organization interested in child welfare work might help you put on a play for this purpose. Do it soon to take advantage of the very special rates for December and January, which have been sent to your Hygeia chairman.

The public and school libraries in Seattle were investigated by the Public Relations chairman and her committee. All books on quackery or written on medical subjects by unqualified authors were removed from the shelves devoted to medical liter-

ature. A Public Relations chairman can prevent practitioners of cults from lecturing on medical topics, get their lectures canceled and replace them with qualified medical men to serve as attending physicians to high school football teams or other organizations. An extensive compilation of all books on medical subjects for popular reading, was made by the Public Relations chairman. The lists were printed and bound in booklet form by the Seattle Public Library and placed in the hands of every county president.

At the Oregon State meeting Miss Grace Hill gave a demonstration on the use of Hygeia by a health teacher. We may soon be able to get a copy of this talk. One thousand copies of Hygeia were distributed at a Washington state fair.

The following is a list of articles of special interest to those interested in matters closely allied to the medical profession. They are recommended by the Press and Publicity chairman:

(1) "Relation Between the General Practitioner and the Public Health Official" by Hugh S. Cummings, M. D. (Journal of The Medical Society of New Jersey, September 1933.)

(2) "The Treatment of Food Allergy in Young Infants" by David Greer, M.D. (Texas State Medical Journal, October 1933.)

(3) "Revolutionary Changes in Medical Practice" by George W. Swift, M.D. (Northwest Medicine, September 1933.)

(4) "Responsibility in the Delinquent Child" by D. G. Davidson, M.D. (The Pennsylvania Medical Journal, September 1933.)

(5) "Federal Court Ruling on Chiropractic" by Lorenz J. Brosman, Esq. (New York State Journal of Medicine, November 1, 1933.)

Mrs. Blake and Mrs. Tomlinson visited Cleveland on October 20, 1933, to make first arrangements for the Annual Meeting in that city next June 11 to 15. We hope there will be a large representation of Auxiliary members from New Jersey at that meeting, so begin to make your plans for it.

Dr. Quigley, President of The Medical Society of New Jersey, recommends that the Auxiliary consider the following lines of work in its program this year:

(1) Develop a speakers' bureau, and assume responsibility for it under the supervision of component societies.

(2) Develop a program to combat false health, food, and drug advertising.

(3) Have the Auxiliary prepared to assist the medical profession in certain types of legislation.

Mrs. Don Epler is preparing a letter soon to be mailed to every county auxiliary, which contains valuable suggestions for your public health work.

We take this opportunity to wish you all a happy New Year.

MRS. HARRY VARSIL HUBBARD.

Atlantic County

Anna M. Malley, Corresponding Secretary

A regular meeting of the Auxiliary to the Atlantic County Medical Society was held in the Blue Room of the Chalfonte Hotel, Atlantic City, on Friday evening, December 8, 1933.

Mrs. Joseph Poland, President, presided.

The members voted to send the annual Christmas donations as follows: Atlantic City Day Nursery, \$5 (to be spent on toys, etc.); Municipal Hospital, \$5; Pine Rest Sanatorium, \$5 (to be spent on gloves); Betty Bacharach Home, \$5; Welfare Federation, \$5; Pleasantville Red Cross, \$10.

Mrs. R. A. Williams was proposed as a new member.

Mrs. W. Blair Stewart was appointed a committee of one to call upon sick members and new members.

The January meeting will take the form of a reception to members of this Auxiliary who reside outside of Atlantic City. The date and place will be announced later.

A social hour followed the adjournment of the business meeting.

Members present: Mrs. David B. Allman, Mrs. Edwin H. Harvey, Mrs. Milton Ireland, Mrs. Samuel Gorson, Mrs. James North, Mrs. Carl A. Surran, Mrs. Baxter H. Timberlake, Mrs. Louis Rosenberg, Mrs. Barney B. Barab, Mrs. Samuel Goldstein, Mrs. Harry Subin, Mrs. Robert A. Bradley, Mrs. Joseph Poland, Mrs. Manuel J. Mally.

Hudson County

Reported by Caroline Culver

NOVEMBER MEETING

The regular monthly meeting of the Woman's Auxiliary to the Hudson County Medical Society was held on Monday afternoon, November 6, 1933, at the Y. W. C. A., on Fairmount Avenue, at 2 o'clock; the President, Mrs. Frank P. Nicholson, presiding.

The minutes of the previous meeting were read and approved.

The Secretary, Mrs. John Connell, reported on the State Executive Board meeting, held at the home of the President, Mrs. Hubbard, in Plainfield, in October. She told of the need for stressing the Widows' and Orphans' Relief Fund; and the hope for 100 new members, at least.

It was voted to elect as honorary members, those who, already being members of the Auxiliary, have become widows, in order that they may continue their affiliation with the society.

The January meeting of the State Executive Board will be an open meeting, and will be held at the Stacy-Trent Hotel, in Trenton.

The December meeting of the Hudson County Auxiliary will be a Christmas party, and a Membership Drive Tea, to be held on Monday, January 4, 1934, at 2 p. m., at the Y. W. C. A.

Mrs. John Nevin will read Dickens' Christmas Carol, and Mrs. John O'Neill, Mrs. Harry Perlberg, and Mrs. Peter Maras will entertain with a musical program.

New business consisted of a report on a family in dire need of help. It was voted to give them some assistance, until such time as the husband could get work.

Miss Hazel Krantz, of the Y. W. C. A., made a stirring appeal to the members to join the woman's

crusade, which is soon to be inaugurated in Jersey City and in all parts of the country; its purpose is to enlist fortunate women to help those less fortunate.

The speaker for the afternoon was Dr. Charles B. Kelley; his subject, "State Licensure for Physicians". Dr. Kelley began his talk with congratulations to our organization; he spoke of many things which we could consider, and which would be of benefit to the community. He said that the social side, too, was very necessary; it had brought physicians' wives from all parts of the county together—people who had never known of each other's existence previously.

He then explained the state licensure law for physicians, telling of the many safeguards provided for the protection of the people as well as the protection of doctors from "quacks" and charlatans. He gave an interesting history of how New Jersey came to pass the present restricting laws; of the appointment of the state board of examiners, and the requirements for licenses by means of strict examinations. New Jersey had this legal measure 4 years in advance of New York. Even so, it was not until 1890 that this state adopted such measures.

Following his talk, Dr. Kelley answered questions and an interesting discussion followed.

Mrs. John Connell and a group of assistants served tea.

DECEMBER MEETING

The regular monthly meeting of the Woman's Auxiliary to the Hudson County Medical Society was held on the afternoon of Monday, December 4, 1933, at the Y. W. C. A., in Fairmount Avenue; the President, Mrs. Frank P. Nicholson, presiding.

Minutes of the previous meeting were read and approved.

The Treasurer and the Corresponding Secretary also reported.

At the November meeting, it was voted to help in the care of a man, his wife, and 5 little children, until the man could find a permanent position. Mrs. Nicholson read a letter of thanks from the wife, in which she expressed their deepest gratitude for the help received.

A collection was taken among the members, and at Thanksgiving time some of the Auxiliary sent a large basket filled with all kinds of good things to make a happy holiday.

This same thing is planned for Christmas time.

Mrs. Berthold Schwarz, as Chairman of the Widows' and Orphans' Relief Fund, pleaded for the Fund and asked the members to interest their husbands to join.

We had no speaker, as it was a social afternoon—a Christmas Party and a Membership Tea.

Ten new members were welcomed; they were introduced to the assembly and warmly greeted.

The program included some excellent music by the members, and a delightful reading of part of Dickens' Christmas Carol by Mrs. John Nevins, given in her inimitable way.

The singer was Mrs. John O'Neill, contralto, accompanied by Miss Rita Smith. Mrs. Harry Perlberg added to the program by playing several

piano solos, and Master Harry Perlberg, accompanied by his mother, contributed a group of saxophone numbers to the delight of all.

The tea-table was gay and festive with Christmas colors; Mrs. Robert Stockfish as Chairman of hostesses, with a group of assistants, served dainty refreshments.

Before the meeting the Executive Board entertained at lunch at Hotel Plaza for our State President, Mrs. Harry Hubbard, of Plainfield. Mrs. Frederick Kinch was also a guest.

The January meeting will not be held until Wednesday, January 3, 1934, as the first Monday is New Year's Day.

Miscellany

WHY WE FEAR GHOSTS

In a recent editorial, the New York Herald Tribune under the above title quotes from Miss M. E. Durham's report to the English Folk Lore Society as to why ghosts still are objects of human fear. Part of the editorial follows:

"This is a relic, Miss Durham believes, of primitive sanitation; of days when intelligent savages, ignorant of what we know about invisible germs, were groping in their minds for some reasonable explanation of the mysterious strokes of epidemic and infectious disease. It was a sound observation that one death in a household was likely to be followed by others. There was nothing unreasonable in concluding that the later deaths were caused, somehow or other, by the first; perhaps because the ghost of the first dead man returned to claim companionship and further services from living friends and relatives.

Thus arose the various methods of ritual purification. The body of the dead was burned or treated with materials such as clay or oils or decoctions of plants found by experience to help lessen the power of the ghost to carry off others. Nowadays we call these antiseptics. Persons associated with the death or the body of the dead were purified by washing and fumigation or were segregated for a time from other members of the community, on the entirely sound idea that they might have been damaged by the influences then called ghosts, now understood as germs. * * * It was held that the dead man's ghost might have entered the family drinking water, the clothing or weapons of the deceased, the dishes from which his food had been eaten, even the hut in which he died. All such articles were thrown away, burned, smashed or buried, so that any lurking ghosts—alias germs—might be destroyed."

Book Reviews

THE STORY OF CHILDBIRTH, by Palmer Findley, M.D., (Doubleday Doran & Co.).

This book was written primarily for the lay reader. It is a pleasure to the lover of good English to read a book written with the clear-cut expres-

sion that characterizes all the writings of Dr. Findley. The history of childbirth is charmingly told from the most ancient times, down through the ages when the whole subject was beclouded with ignorance and befogged with superstition, to the present time.

There is much of interest and information for the physician as well as the layman. Especially to be noted are the chapters on "Martyred Mothers" which delineate the great advances made in safeguarding the pregnant woman of today by careful and conscientious prenatal and postnatal study and supervision; and the chapters on "Birth Control", and the "Lost Art of Obstetrics".

His attitude on cesarean section and other surgical procedures is conservative and sane. Certainly the *furor operativus* of the recent past has been much overdone. In the light of our present knowledge it is rather the wonder that any woman in olden times survived the birth of a child. Dr. Findley in this volume shows beyond doubt that women today, provided they are in the hands of careful well-trained and competent obstetricians, run comparatively little risk in bearing children.

The book is well written, very interesting and full of information. It will repay careful reading by any physician interested in the art and science of obstetrics.

W. E. D.

Obituaries

SMITH, Charles B., M.D., a member of the Board of Trustees of the State Medical Society, died at his home in Washington, N. J., on December 19, 1933.

Dr. Smith, who was 66 years of age, had been ill from heart trouble for some time, although he was at his office only a few days before his death.

Dr. Smith was a son of the late Alfred Smith. He was born in Bethlehem Township, Hunterdon County, and had resided in Washington more than 50 years. He attended the Washington schools, graduating from the high school in 1883. He was a graduate of the College of Physicians and Surgeons, Baltimore, in 1891.

His reputation as a physician and surgeon brought him patients from communities in Warren and adjacent counties. He was mayor of Washington from 1895-1897, 1906, 1910 and 1913-1915 and also had been a member of the Board of Education many years and a trustee of Washington Presbyterian Church. He was chairman of the board of directors of First National Bank of Washington and a charter member and first president of the Washington Kiwanis Club.

Dr. Smith was a member of the New Jersey State Medical Society, the American Medical Association, the Lehigh Valley Medical Association, the Tri-County Medical Association, the Medical Association of Greater New York and the New York and New England Association of Railway Surgeons. He had been surgeon for the Lackawanna Railroad many years. He also had been a mem-

ber of the Washington Board of Health and was active in the social affairs of the borough.

Dr. Smith was a member of the Washington Athletic Association, Mansfield Masonic Lodge of Washington, De Molay Commandery of Washington, Mecca Temple, Order of the Mystic Shrine of New York; the Jr. O. U. A. M., Royal Arcanum, Odd Fellows, Red Men, and Sons and Daughters of Liberty. His wife is the former Miss Mary S. Richey, of Asbury. A daughter, Mrs. Dudley Hance, of Washington, and a grandson also survive.

Funeral services were conducted by Rev. Norman MacQueen, pastor of the Washington Presbyterian Church, assisted by former pastors. Burial was in Asbury Presbyterian Cemetery.

DUNLAP, Thomas G., M.D., 57, surgeon and bacteriologist, died December 15, 1933, at his home, 47 South Virginia Avenue, Atlantic City, from a heart attack. He had been a practicing surgeon and physician here since 1903. Besides his wife he is survived by two sons, John Lee and Thomas G. Dunlap Jr. He was born in Bourbon County, Kentucky. After graduation from the Medical School of the University of Louisville in 1898, he pursued post-graduate courses in medicine and surgery at medical centers, including Bellevue Hospital, New York.

Dr. Dunlap was a member of the Atlantic County Medical Society, New Jersey State Medical Society, American Medical Association, Commonwealth Medical Council of Pennsylvania and the State Board of Health of New Jersey.

His medical and surgical library in Atlantic City is rated among the most complete, costly and rarest of its kind in the state.

KORNGUT, Samuel, M.D., of Elizabeth, died at his home on December 4, 1933. Dr. Korngut was born January 31, 1871, in Austria. Up to the age of 20 years, he was in high school in Dresden, Germany. He came to the United States in 1881, studied at New York University and graduated in 1898. He started to practice in Elizabeth in 1900, and specialized in x-ray and electrotherapeutics.

MUELLERSHOEN, George J., M.D., a member of the Atlantic County Medical Society since 1930, died on December 18, 1933, at Philadelphia, Pa.

Dr. Muellershoen graduated from Jefferson Medical College in 1904. He was chief of clinic of the genito-urinary Out-Patient Department of Jefferson Hospital and a member of the teaching staff of Jefferson Medical College for more than 20 years.

Dr. Muellerschoen, who was widely known for his teaching and contributions to medical journals, was associated in practice with Dr. Thomas C. Stellwagen, noted surgeon, with offices at 220 South Sixteenth Street, Philadelphia. Death followed a mastoid operation.

Born 50 years ago, Dr. Muellerschoen was the son of George Muellerschoen and Mrs. Mary Russ Muellerschoen. He is survived by his widow, Mrs. Marion T. Muellerschoen; a son, George John Muellerschoen, Jr., and two brothers, Frank J. Miller and John Callan, both of Pasadena, Cal.

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A RIGHTFUL FINDING

(Newark Sunday Call, December 3)

The New York Court of Appeals has upheld the constitutionality of the law requiring that a registered pharmacist be on duty during all the hours in which a pharmacy or drug-store is open for business. This is a victory for public welfare, for certainly it is evident that the sale of medicines and allied chemical products should be intrusted only to the skilled pharmacist, who is bound by the code of his profession to exercise the requisite care and ability.

Failure to observe such a common-sense regulation of a responsibility in which the elements of skill and trust are so vital can result only in the establishment of perilous conditions. New Jersey, which has recognized for a long time the practical

priesthood of the pharmacist, has this regulation and has found it good.

OUR VEGETARIAN TENDENCY

(New York Times, November 27)

Regardless of what may come and what may go, everybody insists on eating, not now and then, but every day, says J. B. Shores of the Texas & Pacific Railway. This persistent, deep-rooted habit resulted in the various growers shipping last year a total of 834,562 carloads of fruits and vegetables to the numerous markets of the nation, he asserted. Of this number, there were 7000 cars of honey ball, honey dew and Persian melons, all comparatively newcomers to the American table, for only four years ago they moved in such small quantities that they were not given recognition by the tabulators who keep a check on the movement of fruits and vegetables, he declares.

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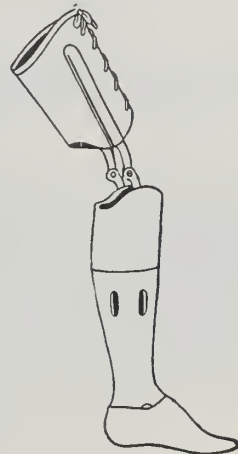
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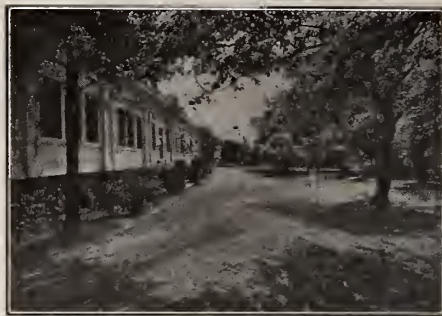
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VIEW OF THE GROUNDS

BOOKLET AND TERMS ON REQUEST

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FORESEES INCREASE IN PULMONARY CASES

(Newark Evening News, December 7)

A "tremendous increase" in tuberculosis cases in 1934 was forecast by Dr. Byron M. Harman, superintendent of Essex Mountain Sanatorium, Verona, at a meeting of the Board of Freeholders' committee in charge of the institution. A cycle of ten years' good health is drawing to a close, the superintendent said, and authorities expect to see undernourishment, caused by the depression, reflected in a high rate of pulmonary cases.

The institution has a patient population of 411 and a waiting list of 63. Forty-three children are on a waiting list to be admitted to Farmingdale Preventorium. Expenditures have gone beyond budget estimates and Dr. Harman said a transfer of \$2000 from some other institution or department will be needed to meet costs this month.

The 1933 appropriation was \$406,250. Dr. Harman estimated \$416,750 would be needed next year. Freeholder Muir, Chairman, who also heads the finance committee and is seeking substantial cuts for 1934, said economies must be made.

The 1934 estimate showed a drop from the \$266,000 payrolls this year to \$253,000. Food supplies, Dr. Harman estimated, will cost \$95,000, or \$2000 under 1933 budget items. Light, heat and power, he calculated, would grow from \$27,000 to \$37,000 next year. Supplies and other expenses will advance to \$33,750. The figure was \$16,000 this year. Conferences will be held to determine where cuts may be made.

The daily per capita cost this year averages \$2.67. It was \$3.10 a year ago. Patient board payments

for 11 months dropped from \$6774 last year to \$4590 this year. Dr. Harman said a patient and nurse had been slightly burned by explosion of a lamp in the physio-helio-therapy department.

Dr. K. E. Gardner, resident physician, is recovering from an appendicitis operation. He and three employees were granted leaves of absence. An early conference will be arranged at which Dr. Harman, Dr. Guy Payne, Superintendent of Overbrook Hospital, and Dr. Ellis L. Smith will discuss proposals for administrative economies.

OPENS NEW DEPARTMENT

The new Physical Therapy Department of the New York Polyclinic Medical School and Hospital was opened on Monday, December 11, 1933. Many prominent physicians and surgeons, as well as other guests were present. This department is located in the new clinic building of the Polyclinic Hospital, and is under the supervision of Dr. Richard Kovacs.

A. M. A. SCIENTIFIC EXHIBIT

Application blanks are now available for space in the Scientific Exhibit at the Cleveland Session of the American Medical Association, June 11 to 15, 1934. The Committee on Scientific Exhibit requires that all applicants fill out the regular application form and requests that this be done as early as convenient.

The final date for filing applications is February 26, 1934. All persons desiring to receive an application blank, should address a request to the Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago, Illinois.



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NEWARK, N. J.

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

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1 "Medicinal Wood Tar Creosote: 1 Methoxyl Content as a Criterion of the Composition of Creosote." JI. A. Ph. A. Vol. XVIII. No. 11, Nov. 1929. Results of chemical researches under the 1928-29 Maltbie Chemical Company Fellowship at Princeton University.

2 "The Bactericidal Efficiency and Toxicity of Creosote and its Components." JI. A. Ph. A. Vol. XXII, No. 3, Mar. 1933. Results of bacteriological and toxicological researches under 1929-31 Maltbie Chemical Company Fellowship at the Philadelphia College of Pharmacy and Science.

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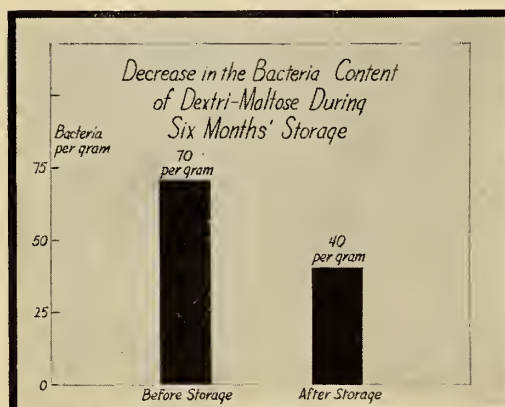
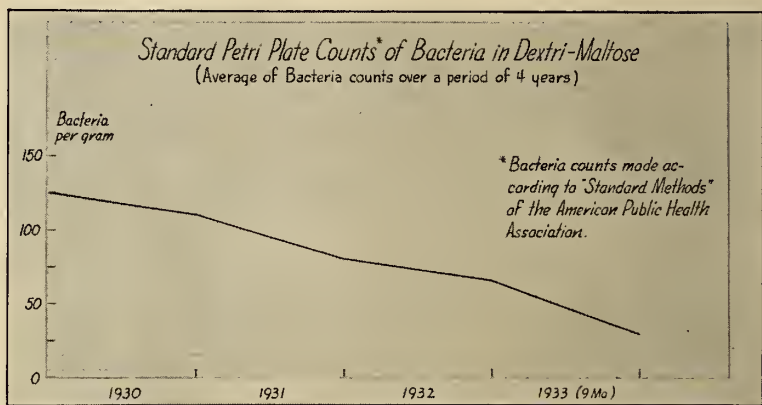
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From the diary of the original Samuel Pepys:

Feb. 21, 1665. And then my wife being busy in going with her woman to a hot-house to bathe herself, after her long being within doors in the dirt, so that she now pretends to a resolution of being hereafter very clean. How long it will hold I can guess.

An apology for Mrs. Samuel Pepys

MRS. PEPYS did not take many baths—but no one did in the 17th Century.

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URGES DEATH FOR IDIOTS AND INCURABLY INSANE

Legal destruction of the incurably insane and of congenital idiots was advocated recently by Dr. Cole Davis, Atlantic City psychiatrist, in an address before the Rotary Club.

"We probably will not live to see the day," he said, "but it is coming. It will become necessary, both to protect society and to ease the burden which is threatening eventually to swamp us.

"Incurables and idiots should be recommended for destruction by the superintendents of institutions after long observation and with the consent of the families, then examined by boards of psychiatrists."

Dr. Davis said that "the 400,000 patients in insane hospitals now cost the United States \$50,000,000 a year, and another \$200,000,000 a year, indirectly. The increase of such persons is at the rate of 10,000 a year; a few years ago it was only 3,000 a year."

The three main causes, Dr. Davis asserted, were "fatigue psychoses," summarized popularly as overwork, worry and breakdown, alcoholism and social disease.

He added that all patients discharged from insane institutions should be sterilized to prevent reproduction.



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In accordance with its annual custom, E. R. Squibb & Sons, during the first week of the year, entertained in New York the winners of gold-star honors of the Squibb Go-Getter Club for 1933.

They were Pacific Coast Sales Manager Ralph W. Keim, of San Francisco, and the following representatives: C. A. Mooney, Los Angeles, Calif.; N. L. Rogers, Bridgeport, Conn.; D. A. Atkinson, St. Louis, Mo.; R. L. Felt, Spokane, Wash.; F. E. Thomas, Denver, Col.; T. I. McGuire, Portland, Ore.; A. H. Taylor, Chicago, Ill.; G. G. Johnson, San Jose, Calif.; J. T. McAloon, Omaha, Neb.; T. C. Hornbuckle, Houston, Tex.; F. H. Lowe, New Orleans, La.; P. W. Macker, Los Angeles, Calif. The Pacific Coast established a new club record by winning the divisional championship two years in succession.

The salesmen-winners of gold-star honors are those who have made the best sales records during the club contest which starts in January and closes at the end of November each year. In addition to monetary and honorary awards, the contest winners, as guests of honor, are invited to the home offices in New York for the enjoyment of a special program of entertainment.

The closing event of the celebration was the annual banquet of the Squibb Go-Getter Club at the New York Athletic Club on Saturday evening, January 6, when the speakers were Carleton H. Palmer, President of E. R. Squibb & Sons; Theodore Weicker, Executive Vice-President; Dr. J. F. Anderson, Second Vice-President; F. W. Nitardy, Vice-President in charge of manufacturing, and R. D. Keim, Vice-President-Director of Sales. General Sales Manager J. C. Hearn was toastmaster.

The guests, more than 100 in number, included the sales managers of the nine Squibb sales divisions of the country, executives, department heads and Canadian representatives.

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SEDATIVES AND COAL-TAR DRUGS LOWER BLOOD PRESSURE

(Hygeia Release, Dec. 18, 1933.)

Although more is heard about high blood pressure than about low blood pressure, a greater number of persons have low blood pressure, it is explained in Dr. Wingate M. Johnson's article, "High Lights on Low Blood Pressure", which appears in the January Hygeia.

Fortunately hypotension, low blood pressure, is not nearly so serious as the opposite condition, hypertension. According to the life insurance companies a moderately low pressure adds materially to life expectancy after the age of 25; but low blood pressure may take much of the joy out of living because of decreased vitality.

Influenza is a leading factor in decreasing the blood pressure. Certain chronic diseases, notably tuberculosis, are characterized by a lowered blood pressure, and it usually accompanies anemia. It may also be due to a weakened heart muscle or to coronary thrombosis, a condition in which the artery that supplies the heart muscle itself is blocked by a blood clot. The habitual use of coal-tar products, including many of the widely advertised remedies for headache, neuralgia and colds, may cause low blood pressure. The same is true of "hypnotics", drugs which produce sleep. Perhaps the chief cause of persistent hypotension is physique. Low blood pressure is most likely to occur in the slender, narrow-chested, long-waisted person because the heart is on a lower level and the blood has to be pumped around a sharper bend than in a wide-chested person.

Patients with chronic hypotension need to keep their weight up to normal, to get at least the orthodox eight hours' sleep every night and to avoid the reckless use of headache remedies and hypnotics.

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CLINICAL SOCIETY PROGRAM OF THE N. Y. POLYCLINIC MEDICAL SCHOOL AND HOSPITAL

During January the following program was presented at the meeting of the Clinical Society at the New York Polyclinic Medical School and Hospital:

January 8, 1934—

Diverticula of the Colon—Jerome Morley Lynch, M.D. (Attending Proctologist to the New York Polyclinic).

Oesophageal Diverticulum: Its Diagnosis, Surgical Management and End Results—Frank H. Lahey, M.D. (Boston), by invitation.

A Plea for the Alexander Method of Shortening the Round Ligaments for Retroversion of the Uterus—Louis J. Ladin, M.D. (Attending Gynecologist to the New York Polyclinic).

January 20, 1934—

The Technic of Version—Dr. Irving W. Potter, of Buffalo (Consulting Obstetrician to the New York Polyclinic).

January 24, 1934—

Diabetes in Children—Dr. Frederick M. Allen (Attending Physician to the New York Polyclinic).



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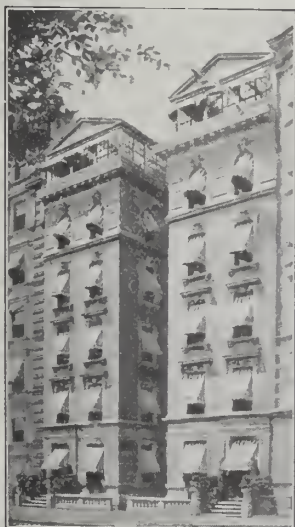
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UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



EDITOR OF
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ALFRED E. SHIPLEY, M.D., Dr. P.H.

OFFICES OF THE SOCIETY—137 EAST STATE STREET, TRENTON, N. J.
EXECUTIVE SECRETARY—LEROY A. WILKES, M.D.

Each member of the State Society is entitled to receive a copy of THE JOURNAL every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.

Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.

Officers, Trustees, Councilors and Committees of the Society are listed on page xxii of the Advertising Section.

VOL. XXXI, No. 2

FEBRUARY, 1934

Subscription, \$3.00 per Year
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EDITORIALS

Impending Legislation

The State Legislature of New Jersey is in session. This means that a tremendous mass of proposed legislation will come before its members for consideration.

A large number of the bills presented in the Legislature are concerned in part or in whole with health and medical matters. An important function of the Welfare Committee of our Society is the close supervision of such legislation. The activities of the Welfare Committee are so varied that it is necessary to delegate certain of its tasks to sub-committees. Legislative matters are being handled by several of these sub-committees.

The sub-committee on Legislation not only thinks in terms of specific measures but outlines the plan of campaign to be followed in order to secure successful completion of the Society's legislative program. On a later page in this issue of The Journal is a report of this sub-committee. We urge our members to read this report very thoroughly. It points out means by which each member can help in this important work.

Three measures of special interest to the

medical profession are being sponsored by the State Society. It is very desirable that they be passed. They are:

(1) Changes in the procedures and administration of the Workmen's Compensation Law.

(2) A measure similar to the Hospital Lien Law which will provide for liens in favor of physicians and surgeons in accident cases.

(3) A Uniform Medical Practice Act.

* * * * *

The Compensation Law of New Jersey was originally passed in 1911. In the administration of the Act, certain provisions or procedures have proven unfair to the injured workman. Those provisions include regulations which affect physicians who take care of these cases. The sub-committee on Compensation, of which Dr. David A. Kraker is chairman, submitted an excellent report including recommended changes. This report is published in the December issue of The Journal, and members are requested to read this article again. This report was materially modified when submitted to the Welfare Committee. The report reviews the various injustices that have crept

into the administration of the Act. The arguments against the choice of physician by the employer or his agent, the Carrier, are presented. The recommendations finally adopted are as follows:

The Committee recommends, as a solution to this problem (1) that the Employer or Carrier discontinue the treatment of compensation injuries or occupational diseases, and substitute a coöperative medical supervision; That the Employee have the right to select his physician and that the Carrier select practitioners of medical standing and experience, who, when a case is reported to the Carrier, will arrange for consultation with the attending physician and advise with him as to treatment. If, in a given case, opinions differ as to the advisability of transferring a patient to the care of a specialist, or, where there is a dispute upon other elements of treatment, or when no satisfactory agreement can be reached, it is suggested that these matters be referred for settlement to the State examining physician in the district.

The Informal Hearings and the various procedures incidental thereto, are criticized. The final recommendations on these matters as approved by the Welfare Committee are quite lengthy. An outline of these recommendations is given here:

The Committee recommends as a remedy for these apparent judicial defects, that the Law be amended to provide for a complete separation of the legal from the medical questions pertaining to the determination of disability claims.

Then follow certain provisions pertaining to:

- (1a) Procedures at the Primary Hearings.
- (2a) Methods of handling disputes as to the claim for physical disability, through appeal to the Medical Board of Referees.
- (2b) Procedures at hearings of this Medical Board of Referees.
- (2c) Findings of the Board, and steps to be taken.
- (3a) Method of appointing the State Physicians.
- (3b) Method of appointing the Medical Board of Referees.
- (3c) The personnel of the Board.
- (3d and e) Duties of the Board.
- (3f) Duties of the State Physicians.
- (3g) Consideration of questions concerning occupational diseases and their prevention, by the Medical Board of the Compensation Bureau composed of the members of the

Medical Board of Referees and the State Physicians.

The Welfare Committee has submitted these recommendations to the Special Commission which was appointed by the Governor to suggest amendments to the present Act.

* * * * *

The present Hospital Lien Law provides for liens in favor of hospitals in accident cases. Physicians are not included in this law, and it is proposed to remedy this defect through provisions in a new bill.

At present, persons injured in accidents receive treatment by physicians for their injuries. Subsequently, such injured persons, or their estates, make claims and demands against the person or corporation whose negligence is claimed or alleged to have caused the accident, and to collect the amount of such settlements *without* paying the charges of the physician or surgeon.

The bill provides that:

"Every physician and/or surgeon licensed to practice medicine and surgery under the Medical Act in the State of New Jersey shall have a lien upon any and all rights of action, suits, claims, counter claims or demands of any person receiving treatment on account of any personal injuries received in any accident as a result of the negligence of any other person or corporation, which any such injured person may or shall have, assert or maintain against any such other person or corporation for damages on account of such injuries, for the amount of the reasonable charges for such medical and/or surgical treatment and for medicine and supplies necessary to such treatment or such injured person up to the date of payment of such damages."

* * * * *

The Uniform Medical Practice Act would require all individuals who practice the healing art to possess certain minimum qualifications with respect to preliminary education and medical training. Thus all practitioners of various cults would be required to have equal standards. The contentions of the medical profession are not against the cults *per se*. Physicians do not protest against competition with persons who offer certain modes of treatment. They do object, however, to such persons being permitted to practice through "back-door legis-

lation". This bill, if passed, would protect the doctor of medicine against unfair competition.

* * * * *

The State Society has no organized lobby at Trenton. On its Welfare Committee are members selected from the component county societies because of their recognized interest in economic and other welfare matters which concern the Society members. Each member of the State Welfare Committee keeps in touch, in his own County Society, with the committee to which legislative matters are referred. Key-men have been or should be selected in each county to see that the state senators and assemblymen are informed as to the true situation with respect to proposed medical and health legislation.

These questions are being asked of each member of the State Society: Do you personally know your state senator or assemblymen? If not, have you a patient or friend who does know them well? If you can answer either of these questions in the affirmative, do not wait for the key-man in your County Society to find this out himself. Make it your business to tell him so. With this knowledge, he will take steps to use you or your friends in the campaign to secure favorable legislation, and to defeat undesirable proposals.

Coördinated efforts in this direction will bring surprisingly favorable results.

Undulant Fever

In an editorial last month, attention was directed to the prevalence of amebic dysentery in New Jersey. Amebic dysentery is only one of several diseases which are being recognized as extant in the States of the north-eastern area.

Undulant fever prevails to a considerable degree. About two years ago, at a meeting of the New Jersey State Veterinary Medical Association, Dr. R. E. Hendershott, chairman of their public health committee called attention to the prevalence of this disease and remarked that, judging from the number of samples of human blood submitted to the State laboratory for examination, a diagnosis of undulant fever was finding favor with physicians. Over a period of six months, 137

samples of human blood were tested, 27 of which gave a positive agglutination reaction. The blood of 9 patients was examined by culture, resulting in the isolation of the micro-organism of undulant fever in 2 instances.

At the monthly meeting of the Camden County Medical Society on January 2, Dr. Grant O. Favorite, a member of that society and the pathologist of the West Jersey Homeopathic Hospital, Camden, discussed undulant fever in a very interesting manner. In this issue, under the Camden County report, will be found extracts from this talk, with special reference to laboratory procedures.

In addition to amebic dysentery and undulant fever, there are other diseases, heretofore rare in these parts of the United States, that physicians may expect to meet.

The United States Public Health Service gives warning to be on the watch for tularemia. It is primarily an epizootic of wild rabbits and is caused by *Bacterium tularense*. Man readily inoculates himself with the disease while dressing rabbits. Cooks, hunters, housewives and market men are often infected at this time of the year when the game laws permit hunting of cotton-tail rabbits for food.

Rocky Mountain spotted fever as its name indicates is a disease found in the mountain regions of the West. Within the past two or three years, a disease of this type has been identified as occurring in States in the eastern and southeastern sections of the United States. This discovery is of interest to the medical profession as well as to health officers. The Rocky Mountain type is spread by ticks, and the evidence so far indicates that the type of disease reported for the eastern States is also spread by ticks. In the Rocky Mountain section the disease often is extremely severe, with mortality running from 60% to 90%. Very recently the need for its differential diagnosis from typhus fever has been pointed out.

Trichinosis is another pathologic condition which has been receiving considerable attention lately. Several outbreaks have been reported in this and adjoining states.

Psittacosis, or parrot fever, primarily a disease of birds, came to the notice of the medical profession in a dramatic way in 1929-1930. At that time 74 foci of infection among

human beings in the United States were located, giving rise to 169 cases with 33 deaths. Since that time other outbreaks have occurred.

It behooves us, therefore as a medical profession to be constantly on guard for unusual clinical pictures and be prepared to interpret them as unusual diseases.

The Fitting of Glasses as a Surgical Procedure

For the past two years one of the leading dispensing opticians of Newark, Mr. J. C. Reiss, has been giving a series of lectures before women's clubs and various civic organizations, stressing the importance and necessity of having glasses fitted by competent medical men. After his lecture, he distributes a questionnaire, and the replies have elicited the fact that most of his hearers have been fitted by opticians or optometrists.

While the laity is greatly in need of such instruction as Mr. Reiss is giving, many members of the medical profession have equal need. Every ophthalmic surgeon has a constant procession of improperly fitted patients, who indignantly inquire, "Why are these men permitted to pose as doctors and do this work?" Not infrequently they express astonishment that their family doctor has sent them to the optometrist for fitting.

The optical business is in a chaotic condition. Every one, from the small hole-in-the-wall jewelry store to the graduate licensed optometrist, fits and sells glasses. As a result, not more than 15% of people wearing glasses are fitted with even an approximate degree of accuracy. The poor, misled by the "eyes examined free" slogan, are the worst sufferers, and are exploited shamelessly. The registered or licensed optometrist bears the same relationship to the medical profession as the chiropractor and the osteopath. It is unfortunate for the public that our legislative bodies have seen fit to license these pseudo-specialists to practice medicine under certain restrictions, since, when they do not conform to these restrictions, it is practically impossible to obtain sufficient evidence to secure a conviction for illegal practice of medicine.

Practically every civilized human being has need of glasses for near-work after the age of 45, and in our modern literate and industrial world, a considerable number of the remainder need them for constant or part-time use. Our knowledge of the fact that errors of refraction and muscle imbalance may have a distinct bearing on general health is in large measure due to the careful observations and astute reasoning of the famous neurologist, Dr. S. Weir Mitchell. The bitter fight waged for 25 years by the Philadelphia School, who championed the theories of Mitchell and Thomson and insisted on the need of cycloplegic drugs for accurate fitting, is trite ophthalmologic history.

The leader in this controversy was the late Dr. George M. Gould, who battled with the ardor of a militant crusader. His voluminous contributions on the subject would make a larger volume than any one of our text books on ophthalmology. His "Biographic Clinics", articles on dextrocularity and sinistrocularity, and the effect of oblique asymmetrical astigmatism in the production of spinal curvature and head tilting, even when corroborated in hundreds of cases seen in the orthopedic clinic of Prof. H. Augustus Wilson at Jefferson, were received with polite skepticism, severe criticism or downright abuse by the leading orthopedic and ophthalmic surgeons of the country.

The importance of *expert* refraction is too well established to ever be relegated to the background, but at the risk of offense to some of our leading ophthalmologists, the question of our present economic distress must be fairly faced and discussed. More than half of most oculists' practice consists of refraction work, which is tiresome drudgery, and many look forward to the time when this work can be turned over to an assistant, with the result that often the quality of the work turned out is in inverse proportion to the eminence of the chief.

In a recent address of the Chairman of the Section on Ophthalmology of the American Medical Association, the opinion was expressed that "the importance of errors of refraction has been and still is greatly exaggerated", and regret was expressed "that the younger oph-

thalmologists are so burdened with refraction work that they are unable to acquire adequate experience in diagnosis and treatment and are unable to perfect themselves in operation work". In the lay press an ophthalmologic chief of a large medical center is quoted as having said that in his opinion too many glasses were being fitted.

With these statements the writer is not in accord. We can not all be "Generals" in the army of ophthalmology. There must be junior officers, and some of us must even be satisfied to serve in the ranks, and the private who serves with distinction may be as great a hero as the chief of staff.

While pathology, diagnosis, therapy and surgery are the high spots in ophthalmology, how often are their results but partial successes, or lamentable failures, while the *expert* refractionist averages nearly 90% of successful results. During the past 25 years, at least 100 operations or variations have been devised for the cure of convergent squint, none of which have the slightest effect in improving the vision of the squinting eye.

Worth's claim made 30 years ago that 75% to 90% of these cases can be cured by methods other than operative, and the vision in the amblyopic, squinting eye partially or wholly restored, has been proved in thousands of cases by hundreds of *expert* refractionists. Oculists see many patients who have run the gamut of all kinds of treatment, and have taken drugs in abundance for headache and other asthenopic symptoms, when a correct pair of glasses afforded complete relief. The general practitioner often makes the mistake of being satisfied with the patient's bare statement that he has glasses, and does not take the trouble to ascertain by whom they were fitted. The oculist should know in every instance by whom his prescription is to be filled.

Just as Mr. Reiss is trying to educate the public as to the advantage of expert fitting by the physician, so should the oculist explain to the patient that expert frame fitting is as important as correct refraction and the desired relief will not be secured with poorly fitted frames or lenses of inferior quality. Second-quality lenses with scratches, striae, bullae, blebs, incorrect centration, irregular and in-

correct axes, are being palmed off on the public by the bushel, and half of the time the patient is ashamed, or too careless, to return to the doctor for a check-up, and the glasses do not afford relief.

When the patient claims he can not afford to patronize the "high priced" optician, the doctor should meet the emergency by reducing his fee and give him a special prescription blank at the bottom of which is printed, "a small-moderate-marked reduction in price is suggested", crossing out 2 of the 3 words "small-moderate-marked".

The writer has found Mr. Reiss and other opticians of his standing always willing to co-operate.

LINN EMERSON, M.D.

Report on the Two Projects Now Being Conducted by the State Society as Community Services

THE E. R. A. MEDICAL RELIEF PROJECT

The organization of the work under the complicated conditions existing in the larger cities necessarily requires more time and effort than in the suburban and rural areas.

Marked progress is now reported for the City of Newark, and the Trenton outlook is much brighter.

Wherever difficulties are met they center about:

- (1) The failure to reach agreements *locally* with E. R. A. Directors.
- (2) The delay in signing and returning copies of the "Uniform Agreement" to the E. R. A. headquarters in Newark and the Executive Offices of the State Medical Society.
- (3) The legal restrictions contained in Chapter 394, Laws of 1931, as amended by Chapter 215, P. L. 1932, paragraph 7:

"The Director shall also have sole authority to appoint such temporary assistants and employees as he may find necessary and fix their compensation and period of service, it being declared as the intention of this authority that in so far as may be found practicable the necessary employees and assistants required by the State Director or by County Directors in the handling of all relief work undertaken

hereunder, shall be recruited from the present public officers and employees of the State, county and municipal governments, and that in all cases they shall serve without compensation."

Dr. Tooker of the State E. R. A. office in Newark in a letter of recent date states:

"I am definitely informed that City physicians and school physicians come under this, and the question of remuneration seems to be definitely settled, as the last phrase of the sentence is "in all cases they shall serve without compensation."

So far, your officers in the State Medical Society have been unable to get an interpretation of this law which will support a different point of view. Continued effort will be made to find a solution. This decision is a handicap to adequate medical service in rural areas for indigents under the E. R. A. Medical Relief Project. It is to the credit of the County Medical Society Medical Relief Committee members that they have shown a commendable and coöperative spirit, and have endeavored to keep in line with the principles and policies mutually agreed upon.

Signing and returning the County agreements would make possible the earlier release of E. R. A. funds for the payment of the doctors for services rendered to E. R. A. authorized cases. No payments can be made until the signed uniform agreement is returned to E. R. A. and Medical Society Executive offices.

The following counties have returned *signed* agreements to the E. R. A. offices in Newark: Atlantic, Cumberland, Gloucester, Hunterdon, Middlesex, Monmouth and Warren. Some of the other counties have signed the former type of agreement and are in operation successfully, but *they too* should sign and return the uniform agreement form recently sent out by the E. R. A. and Medical Society State Executive offices.

One signed copy of the uniform agreement should be kept by *each* of the *county* groups, and one copy should be sent to each of the State Organizations: E. R. A., 29 Washington Avenue, Newark, and The Medical Society of New Jersey, 137 East State Street, Trenton. *Please do this without delay.*

All but two counties have indicated their

desire to participate in the Medical Relief Project.

THE DIPHTHERIA IMMUNIZATION PROJECT

This project has for its primary aim the development of organized medical service *within the profession itself*, by means of which "adequate medical service can be furnished to all the people at a price which they can afford to pay". Dr. Olin West, Secretary of the American Medical Association, says this is the problem which must be solved by the medical profession. The solution of this problem in the opinion of the State Public Health Committee involves two considerations:

(a) The *practice* of medicine—which requires professional training and experience.

(b) The furnishing of medical *services* to the community—which requires training and experience in "business methods" (organization, plans, schedules and dispatch).

Diphtheria immunization is chosen for the 1934 Project because it offers:

(1) A solution to an urgent need in early life. (At the time when parental supervision and protection in the home is most effective.)

(2) A definite objective.

(3) A simple technic.

(4) Individual and group services.

(5) A measurable achievement.

The individual members of the County Medical Society are urged to provide:

(a) "Public Health Hour"—outside the regular office hours. In the Public Health Hour only preventive services of distinctly limited scope are offered—at \$1 per visit for toxoid injection.

(b) In the doctors' *regular* office hours, his usual charges are to be made for his services.

(c) Indigents are to be immunized without charge.

(d) The doctor will decide as to the indigent in each case.

(e) In view of the increased protection afforded the public and the free service given to indigents, Boards of Health should furnish the materials needed, free to physicians in *all* cases.

LEROY A. WILKES, M.D.,
Executive Secretary.

ORIGINAL ARTICLES

GASTRO-INTESTINAL CAMOUFLAGE OF ORGANIC DISEASE

JULIUS GERENDASY, M.D.,
Elizabeth, N. J.

In a previous article by the author, gastro-intestinal symptoms were classified as major or minor, the former suggesting organic disease and the latter functional or possibly reflex in origin.

The purpose of the present paper is to illustrate with case reports, major symptoms apparently caused by intrinsic factors in the gastro-intestinal tract but which really were a camouflage for serious disorders elsewhere in the body.

The gastro-enterologist is a specialist by virtue of his special training and ability to perform certain examinations which clarify his special subject; but primarily he is an internist versed in the problems of internal medicine.

Disturbances in the organs of digestion due to its sympathetic response to lesions elsewhere is axiomatic. With this knowledge before him, the gastro-enterologist evaluates the history and physical findings and places the patient in the right category for proper treatment. The following are a few examples selected to illustrate this procedure as well as to show the importance of careful consideration of each patient admitted to a busy gastro-intestinal clinic.

CASE 1

A. H., age 46, male, white, roof slater by occupation, first seen November 16, 1932. The chief complaint was diarrhea of 5 months' duration. He was having 6 to 8 watery stools by day and 3 or 4 at night associated with tenesmus, lower abdominal cramps and the occasional appearance of bright red blood in the stool. Anorexia, progressive weakness and loss of weight (32 lbs.) has continued since

the onset. Because of the evident seriousness of his illness he was immediately hospitalized.

Temperature, pulse and respiration were normal throughout the course of his illness except for transient rises following intravenous infusions. Several blood examinations revealed a mild secondary anemia with an average hemoglobin of 75%, leukopenia ranging from 2850 to 5400 white cells and a lymphocytosis between 25% and 60%. Wassermann reaction was negative, blood sugar, 87 mg., blood chlorides 600, blood calcium 6.5 milligrams. Urinalysis revealed a trace of albumin and an occasional granular cast. Repeated stool examinations were negative for parasites, ova or tubercle bacilli but occult blood was positive on several occasions.

Sigmoidoscopic examination revealed a pale dry mucous membrane of the lower 10 inches of the bowel with no evidence of ulcerations or malignancy.

The lungs were free of Koch infection on x-ray examination and a gastro-intestinal series including a Barium enema, likewise gave no assistance as to the cause of his diarrhea.

In spite of a previous biopsy of a cervical gland, in another hospital, a gland in the right axilla was removed. The pathologist reported simple chronic lymphadenitis.

In spite of supportive measures, he pursued a gradual but definitely downward course and died 8 weeks after coming under observation. Autopsy revealed lymphoblastoma of the Hodgkin's hyperplastic type, apparently primary in the spleen, with secondary involvement of the mesenteric and retroperitoneal lymph nodes as well as the liver. There were also 2 small ulcerations in the terminal ileum. All other organs were essentially normal.

Comment: This patient appeared to be definitely a gastro-intestinal problem. However, with the exclusion of this tract, lesions else-

From the Gastro-Intestinal Clinics of the Elizabeth General and St. Elizabeth Hospitals, Elizabeth, N. J.

where were sought but not found. Abdominal Hodgkin's was considered and excluded because of the negative biopsy report.

In retrospect, however, it appears that too much reliance was placed on the external (gland) signs of this disease. Symmers has indicated clearly that the enlargement of the cervical nodes in lymphoblastoma is not the rule but that involvement of the tissues within the abdomen is common and often the place where the disease originally started. Under such circumstances Minot and Isaacs are of the opinion that the gastro-intestinal symptoms are sufficiently prominent to be a definite feature of the disease. They, as well as Muller and Boles, cite diarrhea as frequently the initial as well as a persistent symptom. Abdominal discomfort such as this patient presented is quite common. Also, the gastro-intestinal symptoms often persist a long time before there is other evidence of abdominal lymphoblastoma.

CASE 2

G. B., age 32, white, female, housewife, admitted to the clinic January 24, 1932, complaining of epigastric pain radiating to the back. The pain was aggravated by food, and vomiting occurred frequently as a result. Gaseous distress was prominent as was nausea and anorexia. Alkaline powders gave temporary relief. Her bowels were regular but occasional diarrhea occurred after the noon meal. She has lost 5 pounds in weight in the past 2 months. Nocturia occurred twice during the night and occasionally dysuria was present. These symptoms were of 8 months' duration with remissions and recrudescences. For a short period, she was relieved by a Sippy diet prescribed in another hospital where a diagnosis of peptic ulcer had been made.

Her past history included 3 operations during a period of 5 years at which the appendix, both tubes and one ovary were removed.

Physical examination revealed a well-nourished woman of good color. Tenderness was present in the epigastrium on deep palpation; also over the gall-bladder region and the right iliac fossa.

A test meal revealed absence of free hydrochloric acid. A gall-bladder series with the

dye, reported this organ as normal in outline and function. The gastro-intestinal series revealed no ulcer or other abnormality in this tract.

Symptomatic treatment was given without relief. At one of her later visits, a fullness in the thyroid gland, coincident with her regular menstrual period was noted, and a basal metabolism was ordered. This was found to be +57. She was then referred for surgical treatment and was operated upon. The pathologic report of the resected specimen confirmed the diagnosis of hyperthyroidism.

Comment: This patient illustrates clearly the gastro-intestinal phenomenon which may characterize toxic goitre. The picture here presented is frequently not the one we are accustomed to associate with hypersecretion of this gland. The gastro-intestinal signs may precede the metabolic symptoms or be much more pronounced; therefore the diagnosis is often missed, especially, as in the patient under discussion, the cycle of remission and recrudescence characterizes both ulcer and hyperthyroidism.

The conclusion to be drawn is, that to avoid errors in patients with gastro-intestinal symptoms of doubtful origin, careful examinations for other signs of thyroidism should not be neglected.

CASE 3

J. H., age 28, colored, male, married, laborer, first seen April 23, 1931. At that time, he complained of right lower abdominal pain radiating across the abdomen but frequently around the umbilicus. When the pain was severe, it was associated with disabling lower backache. Pain and borborygmus were quite annoying especially as they disturbed his sleep. These symptoms were almost daily in occurrence since March 1931 and were not relieved by the usual household remedies. His bowels were regular and at no time did he suffer with diarrhea. Heartburn was present but no nausea or vomiting. Dysuria appeared off and on but he had noted no hematuria. His best weight was 137 pounds, present weight 118½ pounds.

One year ago, he had a similar attack which gradually wore off after about 6 months. His

habits were good and he denied previous medical or surgical illness. He admitted gonorrheal urethritis in 1922 and 1926, and a penile lesion in 1926 for which he received no treatment.

Physical examination revealed an asthenic, poorly nourished individual. Clinically, there was no positive evidence of pulmonary infection and the heart appeared to be normal. The abdomen was distended and quite tender below the level of the umbilicus. Palpable masses were absent. Pupils and knee-jerk reacted normally. Urine examination was normal. Because of the abdominal pain associated with progressive weakness and anorexia, he was hospitalized.

Further investigation revealed the highest rectal temperature at any time as 99° F., pulse 90, respiration 22. Blood count revealed a hemoglobin of 75%, white count of 11,000 leukocytes, 69% polys, 30% lymphocytes, 1% endothelial leukocytes. Blood Wassermann negative. No tubercle bacilli found in the urine.

A gastro-intestinal series including Barium enema was negative except for marked colonic spasm. An exploratory laparotomy was performed. This revealed plastic tuberculous peritonitis.

Comment: The abdominal symptoms predominated. The most common lesion in a colored patient is either tuberculosis or lues. With the exclusion of the latter condition, the former appeared probable. While tuberculous peritonitis is usually secondary to a lesion elsewhere (pulmonic or glandular) it may occur before these are prominent.

The genito-urinary tract was examined thoroughly with no abnormal findings. At a later date active pulmonary involvement was found on roentgenoscopy.

CASE 4

E. F., age 68, white, male, no occupation, admitted to the clinic with the complaint that for the past 3 weeks, he had been troubled with epigastric and lower abdominal pains. The former came 1 hour after each meal and was gnawing in character. It was relieved by baking soda but more often by vomiting. The vomitus appeared to include the entire meal. The pain would wake him up at night. Anor-

exia has been progressive for the past 2 or 3 months and was attended by a good deal of weight loss. Constipation almost to the degree of obstipation was also present. Headache, frontal and occipital, was almost a daily occurrence. Nocturia twice nightly.

Physical examination revealed a powerfully built man of the hypersthenic habitus. The lungs appeared normal. The heart sounds at the apex and over the aortic valves were accentuated but otherwise appeared normal. The abdomen was flabby, showing definite weight loss. The liver felt very hard with rounded margin. No masses could be felt. Rectally, the prostate felt normal.

When admitted to the hospital his temperature, pulse and respiration were within normal limits; his temperature rose, just before he expired, to 105° F. Urine revealed a trace of albumin and a specific gravity of 1025. The blood non-protein nitrogen was 60 mg. The values for creatinin were not reported. Blood pressure, systolic 180, diastolic 100. Because of persistent vomiting, a gastro-intestinal series was taken. There was no gastro-intestinal lesion present. Urinous odor to the breath, which was noted in the clinic, persisted and he died in uremic coma on the fourth day. The condition probably was aggravated by an exploratory laparotomy with ether anesthesia; the operation revealed no organic lesion.

Comment: It is well known to urologists that renal disorders may originate gastro-intestinal symptoms. In late nephritis this is a frequent occurrence. In the pre-uremic state, or when uremia is already present, the vomiting may stand out as the predominant symptom.

The accumulation of nitrogenous waste products in the blood are excreted into the alimentary tract. The stomach and intestines are excretory organs as well as secretory. The excretion of these products causes gastric and intestinal irritation. At autopsy on uremic patients one often will find submucous (petechial) hemorrhages, small ulcerations in the stomach and duodenum and even larger ones, especially in the cecum. Such a condition, with, perhaps, toxic cerebral irritation would explain the gastric symptoms which so closely simulated organic gastro-intestinal disorder in this patient.

CASE 5

B. C., age 29, white, female, with no occupation, complained that for the past 6 to 7 years she had pain in the right lower abdomen, dull in character and non-radiating. She also had attacks of "colitis" characterized by colicky abdominal pain and followed by diarrhea. Usually she was constipated and used cathartics regularly. Headache, nausea and occasional vomiting were also present. Recently she had some difficulty in starting the urinary stream but dysuria or hematuria was absent. Slight dyspnea occurred on exertion, and now and then she had to sleep on 3 pillows.

Her appetite was capricious. Her weight fluctuated 4 or 5 pounds during the past 3 years. However, she had lost 20 pounds since the onset of her illness. She had always had difficulty with her menstrual period, which was irregular, scanty and associated with dysmenorrhea. The symptoms enumerated above were the high lights of her past history, never constant for prolonged periods, and accentuated by diverse other symptoms. She was never entirely well. At one time, due to a period of somnolence, the diagnosis of possible encephalitis lethargica was made.

Physical examination revealed an asthenic individual of good color and fair nutrition. The heart and lungs were normal, checked by x-ray examination. The abdomen revealed several operative scars; tenderness was present in the right lower quadrant, otherwise essentially negative. She had numerous urine and blood examinations, all of which were entirely normal. Blood pressure was 100 systolic, 50 diastolic. Fractional test meal gave normal acid values. Basal metabolism was -7.

A gastro-intestinal series, in April 1933, was reported as duodenal ulcer and colitis but a later check-up disproved these findings. Cystoscopy on several occasions revealed no genito-urinary disorder.

A thorough explanation and elucidation along the line of constitutional inadequacy appear to have benefited her for the time being.

Comment: The problems involved in this patient are so complex and numerous that a special paper might be written on this subject alone. The diagnoses are usually as multi-

tudinous as the operations of which they are the victims. The enumeration of the diagnoses and operations in her case follows:

Eight years ago it was chronic appendicitis, and uterine prolapse; the appendix was removed and the uterus suspended. In April 1930, the diagnosis was nephroptosis and her right kidney was suspended. In November 1931, "adhesions about the cecum" was followed by exploration. At this time the surgeon noted on his operative sheet, "the stomach is entirely normal, except for its low position, gall-bladder is normal and the liver seems to hang low below the free border of the ribs. The pancreas is normal. The intestinal tract is normal and there is no evidence of adhesions. Pelvic organs are normal." And yet, in June 1933, she had another operation for adhesions. These operations were not done by the same surgeon nor in the same hospital. When she was last seen by us in the clinic, another surgeon had advised another operation for adhesions!

Gastro-enterologists are familiar with this type of patient and label them as chronic intestinal invalids, a term applied to the individual who is usually in rather poor health, with intestinal symptoms predominant. The degree of poor health is variable. Although many get along well for months at a time under favorable conditions, excessive fatigue, either mental or physical, almost invariably precipitates a train of symptoms among which abdominal pain and intermittent diarrhea or constipation predominate. These patients are usually of the high-strung and excitable type. Their posture is bad, the circulation poor, the brain hyperactive; but the body is usually physically inefficient. However, there is no organic abdominal lesion. They are constitutionally inferior in structural development and function. By their numerous and wholly unsatisfactory operations, "ye shall know them".

CASE 6

E. W., age 46, white, female, housewife, first seen May 22, 1933. She complained of severe burning epigastric pain which radiated upward over the chest and backward between the shoulder blades. She thought the pain was worse when the stomach was empty, so she ate

hourly, usually milk, but with only temporary relief. Alkalies also relieved her. These pains were quite severe and disturbed her rest at night. When the epigastric pain was eased, she would have mid-abdominal cramps or a sense of weight in the suprapubic region. The latter was attended by some dysuria. She was very nervous and irritable. Occasionally, she was nauseated but never vomited. Bowels usually regular but used cathartics at intervals. Appetite was capricious. She had lost a few pounds in weight. Her menstrual period was of the 28-day type but except for dysmenorrhea was normal. She had never been pregnant.

She stated that 21 years ago she had pulmonary tuberculosis and 3 years later a gastro-enterostomy was performed supposedly for peptic ulcer; both of these conditions occurred in England. She had a tonsillectomy 2 years ago. After 2 months at home, she was hospitalized in order to confirm the possibility of gastro-jejunal ulcer.

Physical examination on the day of admission was difficult because she was highly excited and apparently in much pain, a condition which marked most of her stay in the hospital. She was fairly well nourished. The heart and lungs were normal. The abdomen was tense and appeared quite tender on palpation over the epigastrium. A scar was noted over this area. The liver and spleen could not be felt and the rest of the abdomen was essentially negative. The temperature, pulse and respiration were normal throughout this period of observation. The blood count revealed hemoglobin 90%, leukocytes 7800, the differential counts within normal limits. The blood Wassermann was negative. The urine normal on several occasions. The stool showed no occult blood on 5 or 6 occasions, nor were undigested fat, ova or other parasites present. The test meal on 2 occasions revealed no free hydrochloric acid and no occult blood. Fluoroscopically, the heart and lungs were normal. A gastro-intestinal series revealed no marginal or jejunal ulcer. This was confirmed by a second and later examination. The gall-bladder series with dye gave normal results.

She was observed very thoroughly over a period of about 7 weeks as the magnitude of her complaints seemed out of proportion to

the findings. During this period she was, part of the time, uncontrollable, talked loudly and disturbed the ward patients. She insisted frequently that her husband be called. She made herself quite objectionable to the nurses and resident physicians. At times, however, she kept the nurses in gales of laughter by her witty remarks. In spite of various efforts to relieve her she complained bitterly when visited. Eventually her confidence was gained and she unfolded a long story of marital fear and discord extending over a period of 9 years.

Comment: Many disorders which affect human beings are purely psychogenic. The body performs its functions as a whole through coördinating activities of the central nervous system. This in turn is under the control and guidance of the cerebral cortex; in other words, the mind. While the organs of digestion are essentially autonomous in function, still psychic and emotional states influence them very materially.

Psychic emotion that is repressed may find an outlet from the unconscious in a variety of ways. In the patient under discussion, it was by somatic channels, which gave rise to visceral symptoms, simulating very closely the clinical picture of organic disease, namely, a marginal ulcer.

The recognition of such disorder is by exclusion. All the usual methods of clinical procedure which are of value in excluding organic disease should be used. When this has been accomplished, cultivating the patient's confidence will often elicit some source of strain and conflict which has initiated the masking symptoms. For appropriate treatment the patient is then directed to a competent psychiatrist.

CASE 7

M. T., age 30 years, colored, female, housewife, complained of gastro-intestinal disturbances at irregular intervals for the past 7 years. Gnawing epigastric pain, occasionally radiating to the left upper quadrant, would appear before meals and be relieved by food. These pains would recur daily for several days and be followed by intervals of relief. Gaseous distress and belching were associated. At times, she had severe hunger accompanied by

weakness in the epigastrium and dizziness, but food relieved this also. And yet, ordinarily, her appetite was poor. She complained of marked thirst and polyuria at certain periods. She noted that muscular exertion—a heavy wash or a long walk—caused marked fatigue and her “legs would give way”. Periodically, parietal headaches occurred. These symptoms have become more frequent during the past 3 years.

Her habits were good. On account of the present economic stress she often had only 2 meals a day. She has been married 14 years and has two healthy children. No miscarriages. Her menstrual periods ceased 7 years ago.

Her past history included an attack of pleurisy 8 years ago; also attacks of unconsciousness for which she was hospitalized 5 times in the past 3 years. These were thought to be due to epilepsy. In March 1932, during one of these episodes she came under our observation.

Examination at that time revealed a well-nourished colored woman in deep coma. Supra-orbital pressure gave no response. The body was cold. There was no hyperpnea, acetone or alcoholic odor to the breath. The pupils were dilated and reacted very sluggishly to light. The heart and lungs appeared normal. Abdominal rigidity or masses were absent, as well as signs of cerebral catastrophe.

The temperature was 95° F., pulse 40, respiration 20. Urine examination was normal, blood pressure, systolic 116, diastolic 90. The spinal fluid was normal except for decreased sugar content. The non-protein nitrogen was 35. With all these facts before us the cause of the coma was still a puzzle. We then considered the possibility of hypoglycemia, which was confirmed by a blood sugar of 45 mg. per 100 cc. of blood. Further confirmation was obtained by the immediate response to 10% glucose (1000 cc.) infusion. She became conscious, oriented, and continued so until her discharge.

Additional history elicited the fact that the onset of coma was preceded by chilliness, severe enough to cause the teeth to chatter, then an overpowering somnolence followed by unconsciousness. At times the coma was not so deep. At a previous hospital admission else-

where, it was noted that she talked incoherently and exhibited meaningless movements of the hands, jaws and lower extremities. She could be aroused and appeared to understand questions, but the mentality was too fogged for intelligible response. Four previous hospital admissions were traced and the diagnosis each time varied from hysteria, epilepsy to acidosis. In each episode the admission temperature was subnormal. The period of unconsciousness appeared to last about 12 hours and recovery would be accompanied by excessive hunger and thirst.

Subsequent tests revealed no anemia, negative spinal and blood Wassermann, low acid values in the gastric contents. The basal metabolism on the fourth day was -21 ; the blood pressure, systolic 160 and diastolic 110. The sugar tolerance test: first hour, 68 mg.—second hour, 125 mg.—third hour, 80 mg.

Gall-bladder x-ray with the dye, outlined this organ well but its evacuation after a fat meal was prolonged. Gastro-intestinal series were normal. X-ray of the skull revealed destruction of the sella turcica.

Comment: In this patient the gastro-intestinal symptoms indicated serious organic disease, namely chronic hypoglycemia. The existence of this condition, exclusive of the insulin diabetic type was first mentioned by Seale Harris and others.

In the cases previously reported the etiologic factor appeared to be pathology in the islet cells of the pancreas. Hoxie and Lisherness believe, however, that the cause may also lie in a general depression of the metabolism of the body or a disorganization of the vegetative nervous system. In the present case, the endocrine factor may be responsible as shown by the low basal metabolism and the destruction of the sella turcica, as well as the cessation of the menstrual period at an early age.

The suggestion is offered that henceforth blood sugar determination be included as a routine laboratory procedure in all unconscious patients of undetermined cause.

CONCLUSIONS

We have illustrated with case reports, 7 instances where no disease of the digestive tract was present and yet the most marked symp-

toms were gastro-intestinal. What is the mechanism which disorients the symptomatology from the pathology? A review of the nerve supply to the abdominal organs will permit a better understanding of this transference of sensation. The abdominal viscera receive their innervation from the cerebro-spinal and the sympathetic systems. The former includes the vagus and the splanchnics; the latter, the ganglion along the spine, which, extending through the various plexuses and ending in the abdominal organs, carries vaso-constrictor, vaso-dilator, motor, and inhibitory fibers. Stimuli, such as pain, are carried by these fibers to one or more segments of the cord and thence to the brain. The pain is attributed to the peripheral distribution of the spinal nerves which

emanate from the segment of the cord irritated. This accounts for the propagated sensation being felt in areas other than those in which they are produced. Bahen classifies such propagated sensations into associated, referred, projected, reflex, transferred and sympathetic. The cases reported illustrate most of them. Even in the patients with endocrine etiology (hyperthyroidism and hypoglycemia) the effect on the vegetative nervous system is through their internal secretions. Finally, in arriving at a diagnosis, utilization of every new diagnostic or therapeutic armamentarium is necessary.

In presenting this material, I wish to express my appreciation for the able coöperation of my clinical assistant, Dr. George Stein.

CORONARY THROMBOSIS

With Special Reference to Its Differentiation from Abdominal Surgical Conditions

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For many years coronary obstruction was regarded by internists, great and small, as a severe form of angina pectoris, and termed by them, status anginosus. The frequent occurrence of coronary obstruction in those already the subjects of angina pectoris, as well as the occurrence of certain important symptoms common to both conditions, tended to postpone the time when they should be clearly distinguished from each other, and from other conditions as well.

Sir William Osler, master clinician, student, teacher, writer, and scholar, in his Lumleian Lectures given in 1910, describes quite accurately the postmortem findings of coronary occlusion, but classifies the cases in which they occurred as severe forms of angina pectoris. Even Sir James Mackenzie, accurate observer of clinical phenomena, pioneer in modern cardiology, in his last work on Angina Pectoris, published in 1923, had not sufficiently advanced

his knowledge to be able to recognize coronary occlusion at the bedside.

During the past few years the morbid changes and their clinical manifestations have been accurately correlated until at the present time difficulties in diagnosis by the competent few occur only in atypical and unusual forms.

The medical profession generally has been somewhat slow to utilize this added knowledge, despite its able presentation by several leading writers and teachers. The present communication is an attempt to epitomize the subject from a practical clinical standpoint, with emphasis placed upon the diagnosis, particularly with regard to angina pectoris and upper abdominal surgical conditions.

The terminology presents various synonyms not entirely interchangeable but partially descriptive, such as, coronary occlusion, coronary obstruction and coronary thrombosis; the result of any one of these conditions is, of course, cardiac infarction with softening of the myocardium—myomalacia cordis.

Coronary occlusion may be defined as an acute affection of the heart, the outgrowth of morbid changes in the coronary arteries, leading to infarction of the myocardium, manifested clinically by intense, persistent, precordial pain, various circulatory, respiratory and constitutional symptoms, and a course of variable duration leading to recovery, death or invalidism.

From the pathologic standpoint, coronary occlusion may be regarded as an arterial accident occurring in connection with a diseased artery, constituting one of the important forms of vascular disease.

ETIOLOGY

In general, the remote causes of coronary thrombosis are identical with those of arterial sclerosis since the underlying morbid changes are essentially the same, with special reference to the coronary arteries. It is particularly the arterial changes found in middle life in robust and energetic men, rather than the calcareous deposits in the arteries of old age, that result in coronary thrombosis.

Arterial hypertension, the result of general arterial changes, commonly precedes coronary thrombosis for a considerable period of time. Of major importance is a knowledge of the fact that arterial changes may be restricted to the coronary artery and its branches, or disproportionately affect them; in which cases, thickening of the systemic arteries and consequent arterial hypertension, as well as retinal changes, will be absent.

The intimate interrelations of coronary narrowing and angina pectoris should be clearly apprehended. Coronary thrombosis is usually a dramatic episode in the course of angina pectoris. In a general way, both affections are the outgrowth of the same underlying etiologic factors. Many pathologic as well as clinical conditions are common to both of them. Angina pectoris, in either its minor or major forms, precedes coronary thrombosis in the vast majority of cases, and is often a terminal event. Occasionally, angina pectoris follows coronary thrombosis without previous occurrence. Rarely, there is no association whatever between the two conditions, which in the light of more recent exact knowledge must be

regarded as separate and distinct conditions, notwithstanding their confusion in the past.

The mild form of diabetes occurring in those past middle life is a frequent concomitant of coronary thrombosis. The common association of arteriosclerosis with diabetes makes the causal relations obvious.

Syphilitic aortitis is an important factor in those under 40 years of age but of much less importance in the older cases. Other important predisposing factors are gout, mental stress and nervous strain. Tobacco and other toxic agents have a causal relation difficult to appraise. Rheumatism, of major importance in the production of valvular disease, the other acute infectious diseases and focal infections, seems to have but little importance in the causation of occlusion of the coronary artery.

Personal predisposing factors of importance relate to age, sex, constitution, heredity, occupation, habits and previous affections. A typical case is that of an overweight robust male past the middle period of life who has worked hard and lived carelessly; who eats, smokes and drinks to excess; whose arteries are thickened and who exhibits arterial hypertension and cardiac enlargement; and who has previously suffered mild or severe attacks of angina. Sometimes there is a history of arterial affections in successive generations, or their occurrence in several members of the same family.

AGE INCIDENCE

The age incidence of occlusion of the coronary artery is that of sclerotic and degenerative affections, particularly of the arteries. It is greatest from 60 to 70 years of age; the sixth decade exhibits the next largest number of cases. The great preponderance of cases in an age table would cluster about the sixtieth year. The younger cases are apt to be syphilitic. The calcareous arterial deposits of old age have little importance in this condition.

SEX INCIDENCE

Four-fifths of the cases occur in males, notwithstanding the fact that arterial hypertension is more common in females.

Stress and strain, mental and physical, and the excessive use of tobacco and alcohol in

males may account for the greater number of cases among them. However, if alcohol and tobacco are important etiologic factors in the production of coronary artery disease, we shall expect to encounter the condition among women with increasing frequency in the next few decades.

Those engaged in intellectual pursuits are more prone to coronary thrombosis than those who labor with their hands.

After 40 years of age, vascular diseases and accidents are the most frequent causes of death; athletes are prone to such deaths at a comparatively early age; in those of spare build, coronary thrombosis is not common.

MORBID ANATOMY

The chronic lesions found in fatal cases consist of sclerosis and atheroma of the first part of the aorta; sclerosis, atheroma and narrowing of the coronary vessels; and degenerative changes in the myocardium. Rarely is there associated valvular disease. General arterial sclerosis is often present but may be entirely absent, the arterial changes being restricted to the coronary arteries; even in the coronary tree the distribution of the lesions may be uneven.

The essential and characteristic lesion of the acute condition is infarction of the heart muscle. This is the result of complete closure of the lumen of a branch of the coronary artery, usually due to the formation of a thrombus over an atheromatous patch; less often to obliteration of the lumen from an obliterative endarteritis; rarely to an embolus.

A knowledge of the distribution of the coronary arteries is essential to a clear understanding of the pathologic and clinical features.

The right or posterior coronary artery supplies (1) the entire right ventricle with the exception of the left third of the anterior walls; (2) the right half of the posterior wall of the left ventricle; and (3) a small posterior strip of the interventricular septum.

The left or anterior coronary artery supplies (1) all of the left ventricle with the exception of the right half of the posterior wall; (2) the small left anterior third of the right ventricle not supplied by the right coronary

artery; and (3) a small anterior strip of the interventricular septum.

The areas of junction of the two arteries on the posterior surface of the left ventricle and the anterior surface of the right ventricle, are supplied by both vessels, between which there is free anastomosis.

The left coronary, or one of its main branches, is the vessel most often occluded. The most common site of occlusion is in either the anterior descending branch, or the circumflex branch, of the left coronary about 1 inch from the bifurcation of the main vessel.

The obstruction produces an anemic infarct of the heart (*myomalacia cordis*) generally in the anterior, apical portion of the left ventricle, or near the base of this ventricle and in the interventricular septum. The infarct in its greatest dimension varies from 2 cm. to 8 cm. If it involves the entire thickness of the heart wall, both the overlying pericardium and underlying endocardium will be involved, producing in the first case a plastic pericarditis, and producing in the second case mural thrombosis, the latter the source of embolism of the brain, lungs, kidneys, spleen, and limbs. Mural thrombosis is much more common than pericarditis. It may be present in both the right and left ventricular cavities from blocking of a branch of the anterior coronary supplying the interventricular septum.

SYMPTOMS

The onset of coronary obstruction is usually preceded by anginal attacks, from the seizures of which the condition under discussion clinically and fundamentally differs. Unlike angina pectoris, there is no immediate precipitating cause; many of the cases have their beginning during inactivity, although a few follow some unusual effort. Infarction may occur in the absence of effort and during rest. The outstanding but not constant symptom is severe persistent chest pain, most often referred to the region between the nipples, described as crushing, constricting, vise-like, or agonizing in character, and often radiating to the neck, shoulder and down the arms. The pain is continuous over a period of hours or days, is but little if at all relieved by vasodilators or antispasmodics, and is but slightly lessened by or-

ordinary doses of morphine. There are great mental anxiety and apprehension, often a conviction that death is at hand. Agitation, shock, chilliness and collapse symptoms may occur and be evident by ashen pallor, cyanosis, a cold clammy skin, rapid breathing, great weakness, and profound circulatory disturbances. Nausea and vomiting may occur. Slight fever and leukocytosis develop after a number of hours. Examination reveals distant feeble heart sounds with gallop rhythm. The pulse rate rises and the blood pressure rapidly falls, often to low limits. The pulse becomes small and thready and may be imperceptible. Pulsus alternans, premature contractions, heart-block, transitory auricular fibrillation, ventricular tachycardia may develop shortly after the onset. Dyspnea and Cheyne-Stokes' breathing occur.

The signs of congestive heart failure such as cyanosis of the lips and fingertips, venous engorgement, the signs of pulmonary stasis, and slight hepatic enlargement may rather rapidly follow the onset.

The pericardial friction sound is the most distinctive sign, but is present in only about one-sixth of the cases, develops after the lapse of one or more days, but may occur in a few hours. It is most often heard in the fourth interspace inside the left midclavicular line, is to and fro, and is usually less intense than the friction rub of rheumatic pericarditis.

Pain, the most characteristic symptom, may be of slight intensity, or absent altogether. It may be referred to the abdomen and be associated with rigidity. It may pass through to the back and resemble the pain of gall-stone colic.

Cardiac infarction may occur in the course of congestive heart failure, and be obscured by symptoms already present. Fall of blood pressure may not occur, and is especially unlikely in the unusual involvement of the right coronary artery. The pulse rate may not be disturbed.

The elevation of temperature may be evident only if rectal readings are taken, the ordinary surface temperature being below normal.

Course. The pain may lessen in intensity after a number of hours or days or be recurrent for 4 or 5 days and then disappear.

The blood pressure falls rapidly and usually

markedly, and rises with organization of the infarct but seldom reaches its former level.

The elevation of temperature occurs early, is slight, and lasts for several days; occasionally for 10 or 12 days.

It is accompanied by a leukocytosis over the same period of time. Leukocytosis is an almost constant accompaniment.

The friction sound tends to disappear early after a duration of several days.

ELECTROCARDIOGRAPHIC FINDINGS

This special method of examination is sometimes of inestimable value in a difficult case, and the findings in themselves quite conclusive.

Certain changes in electrocardiographic curves are characteristic and often in themselves adequate to a diagnosis, though not invariably so. Characteristic findings often occur early, and in a doubtful case may be of great help.

A high take-off of the T wave from the downstroke of the R spike before it has reached the base line, a disappearance of the normal isoelectric interval between the R and T waves with a peculiar rounded hump of the T wave, is conclusive evidence of cardiac infarction. The foregoing changes may be seen in any 1 of the 3 customary leads. Less frequently encountered, but of the same significance, is a low take-off from the S wave before it has reached the base line. The use of the fourth or body lead is sometimes helpful and may even be the means of identifying the particular ventricle involved.

The foregoing constitute early changes. The findings change from day to day in greater degree than is shown by any other condition.

The subsequent changes chiefly concern the T waves which gradually recede from their high position, gradually develop a peculiar sharp inversion, and finally appear as a sharp inverted V-shaped curve. The latter finding is significant of myocardial infarction occurring a number of days or weeks previously.

A prominent Q wave in lead 3 may have some importance.

Other changes are significant of associated conditions such as myocardial degeneration, interference with the function of the conduction system, premature contractions, and auricular

fibrillation. The recognition of ventricular tachycardia by this method is of special importance.

COMPLICATIONS

The important complications will be indicated without detailed discussion.

(1) Rupture of the heart with hemopericardium and sudden death from the fifth to fifteenth day.

(2) Rapidly developing acute congestive heart failure with venous engorgements and visceral congestions.

(3) Embolic phenomena after the first week relating to:

- (a) the brain with hemiplegia;
- (b) the lung with hemoptysis;
- (c) the kidney with hematuria;
- (d) the spleen with enlargement and tenderness;
- (e) an extremity with gangrene.

(4) Suppression of urine from arterial hypertension.

(5) Disturbances of the heart beat:

- (a) premature contraction of either auricular or ventricular origin;
- (b) heart-block either partial, complete, or that form due to involvement of a branch of the bundle;
- (c) Auricular fibrillation transitory or persistent;
- (d) Paroxysmal ventricular tachycardia;
- (e) Gallop rhythm;
- (f) Ventricular fibrillation with death.

DIAGNOSIS

For a number of years after this condition was first accurately set forth, the diagnosis was seldom made except by the more accomplished physicians. With a more general knowledge of the occurrence of this affection, the tendency has been to mistake other conditions for coronary occlusion.

Cardinal diagnostic points are: age; previous occurrence of angina pectoris and arterial hypertension; pain not relieved by the nitrites; a sense of constriction in the chest; fall in blood pressure; rapid, thready pulse; feeble heart sounds of fetal type; pericardial friction sounds; collapse symptoms; fever; leukocyto-

sis; embolic phenomena in the second week; and characteristic electrocardiographic curves undergoing changes within short periods of time.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis chiefly concerns angina pectoris, acute abdominal conditions, atypical pneumonia, and less frequently other acute conditions.

Angina Pectoris. The most common error is that of confusing infarction of the heart with angina pectoris, in which latter condition coronary obstruction is usually intercurrent and to be regarded as an acute arterial catastrophe. The error is also an historical one; until recently, it was an error in which all clinicians shared equally. Time may be essential to a correct diagnosis. Of importance are the origin, duration and severity of the pain. The pain in angina pectoris is related to effort, is relieved by rest and nitroglycerin, lasts but a short time, and is unattended by circulatory disturbances or marked constitutional reactions. The pain of infarction of the heart, however, may be spontaneous in origin, is intense in character, lasts for hours or days, and is not relieved by rest or the use of nitrites; there are leukocytosis, fever, profound effects upon the heart action, pulse disturbances relating to rate, volume and rhythm, falling blood pressure, occasional plastic pericarditis, shock, collapse, dyspnea, nausea, vomiting, congestive heart failure, and embolic phenomena.

Acute Abdominal Conditions Simulated by Coronary Occlusion. The importance of an accurate diagnosis in doubtful cases of abdominal affections is obvious. It may be emphasized that in those individuals past 40 years of age who exhibit acute fulminating pain in the upper abdomen, coronary thrombosis should be considered.

Common to certain abdominal conditions and coronary occlusion are the following: rapidly developing, spontaneous pain of intense character, chiefly referred to the upper abdomen; muscular rigidity; epigastric tenderness; vomiting; followed by shock; collapse; fever; leukocytosis; and even jaundice and enlarged liver. With slight modification of the descrip-

tion, these are the symptoms of gall-stone colic, perforated peptic ulcer, acute pancreatitis, acute appendicitis, and of various acute intestinal conditions. A laparotomy in such circumstances may prove fatal; indeed, the occurrence of tragedies, the result of this error, is already a matter of record.

Of cardinal importance in recognizing a coronary affection in doubtful cases is a history of arterial hypertension, previous attacks of angina pectoris, a sense of constriction in the chest although the pain may be almost entirely abdominal, aching in the arms, dyspnea, progressive fall in blood pressure, a rise in the pulse rate, feeble heart sounds, gallop rhythm, pericardial friction sounds, and the distinctive electrocardiographic findings early in the course.

Pneumonia is only superficially simulated in its atypical forms, in those forms of coronary thrombosis in which the chest pain is comparatively mild, and the presence of slight fever, leukocytosis, and congestive râles at the bases divert attention from the heart and circulation and direct attention to the lungs.

Other Conditions. In a small number of cases of coronary thrombosis in which pain is entirely absent, the occurrence of cerebral embolism from detached mural thrombi may produce hemiplegia and simulate cerebral hemorrhage. Routine, systematic examination of the heart and circulation in doubtful cases, bearing in mind the cardinal features of both conditions, will usually dispel uncertainty.

The frequent occurrence of glycosuria in coronary disease has sometimes given rise to confusion in diagnosis as regards acute pancreatitis and diabetic acidosis and coma.

Anaphylactic shock is another condition which may simulate coronary thrombosis.

PROGNOSIS

In an individual case prognosis is difficult. There is no constant relation between the general severity of the symptoms, and the outcome of the illness. Every case must be regarded with concern; few cases, if any, are entirely hopeless. What appears to be a mild case progressing favorably, may die suddenly without warning 5 to 7 days after the onset. By contrast, a patient with violent symptoms

may ultimately recover. Obviously, the prognosis must be guarded in every case, but hope of recovery may be entertained in nearly all of them.

Of unfavorable prognostic import are marked shock, collapse symptoms, systolic blood pressure below 85 mm. Hg, an imperceptible radial pulse, unconsciousness, the occurrence of complete heart-block, attacks of auricular fibrillation, paroxysmal ventricular tachycardia which may lead to ventricular fibrillation, rapidly developing congestive heart failure, and embolic phenomena.

Other findings, including the electrocardiographic studies and personal factors, are of little value in forming a prognosis.

More than one-half of the cases which come under observation die in from 1 to 5 weeks. During the second week, the greatest number perish usually as the result of rupture. Some die instantly at the onset and the cause of death is determined by the coroner's physicians, who long have known coronary thrombosis as a cause of sudden death. Some cases of angina pectoris perish in this way, probably as the result of ventricular fibrillation; this last named condition may occur during the course of infarction of the heart. Others, early exhibit profound shock, weakness, collapse, rapidly falling blood pressure, profound cardiac and circulatory disturbances, and perish in a few hours. Still others partially recover from severe disturbances occurring at the onset and die suddenly from rupture after several days or less frequently after 4 or 5 weeks. Complications due to acute cardiac failure, embolism, suppression of urine, pulmonary conditions, and gangrené may be the cause of death. In those who recover from the immediate effects of the obstruction, the expectation of life is on the average about 3 years, with individual cases departing widely from this figure. Progressive heart failure, heart-block, and a recurrence of coronary obstruction may be the final terminal factors.

In those who recover from the effects of the coronary occlusion, and in whom organization of the infarct, and mural thrombi have taken place, the subsequent course varies. In the group in which angina pectoris has preceded the occurrence of thrombosis, the blood pres-

sure rises with recovery but does not attain the former levels. In such circumstances, no further anginal attacks may occur, and in a sense the patient is in better health than previously.

On the other hand, in a small group of cases previously free from angina, the condition develops after occlusion and recovery therefrom has occurred. These are the cases in which the fall in blood pressure had been slight or in which with recovery the pressure returns to its previous levels.

A third group is formed by those who make a partial recovery, and then enter upon a period of progressive heart failure attended with visceral congestions, respiratory embarrassment, dropsical effusions with or without auricular fibrillation, which, intermittent early, later becomes permanent.

Those who recover from cardiac infarction may subsequently suffer a second involvement with a fatal termination. Conceivably even more than 2 attacks may occur.

TREATMENT

Rest is the first and most important indication of treatment. The patient with infarction of the heart should immediately be placed at absolute rest in bed, free from visitors, unnecessary examinations, anxieties, bothers and worries. Insistence should be placed upon the use of the bedpan and the urinal. The nurse should feed the patient, should assist him in changing his position and should, during the first 2 weeks, endeavor to spare him all effort or exertion. The routine may be somewhat relaxed after 2 weeks, but should continue over a period of 6 or 8 weeks, at the end of which time, gradual resumption of ambulatory activities may cautiously begin. Regulation of the diet and attention to the bowels are obvious measures of importance in management and nursing. Avoidance of straining at stool is important and is to be avoided by dietetic measures, enemata and laxatives.

The second important indication is the relief of pain. At the onset the agonizing pain urgently calls for relief. The nitrites are useless. Morphine hypodermically should be given in relatively large doses until some relief is experienced. Usually its administration is required over a period of several days, at the end of which time the pain may lessen.

In those patients in whom the general condition is good, rest and morphine may be all that are required. In the presence of shock, cold sweat, ashen gray color, and feeble running pulse at the onset, stimulation may be given. The blood pressure is the best criterion in these cases, and if maintained at a systolic pressure of 100 mm. Hg or over, stimulation is usually unnecessary. If the pressure falls below 100 mm. Hg, the intravenous or intramuscular injection of caffeine sodium benzoate (0.5 to 1.0 gm.), strophanthin (gr. 1/250), or adrenalin intramuscularly, may be used. The value of blankets, hotwater bottles, and electric pads is obvious.

Stimulation after the first few days is contraindicated by reason of the increased liability to rupture of the softened infarct—a danger not present at the onset. Digitalis is contraindicated for the same reason and also because of the liability to detachment of mural thrombi and consequent embolism elsewhere in the body.

If dyspnea, Cheyne-Stokes' respirations, and cyanosis are early marked features, the use of oxygen is good practice, and may give considerable relief.

The period of greatest danger of rupture or embolism is between the fifth and fifteenth days. Congestive heart failure, if it occurs, is most likely to take place in the following period, when the use of digitalis, diuretics, even venesection may be used to control the results and, more particularly, auricular fibrillation when present.

Convalescence in uncomplicated cases may be considered as beginning at the end of 6 or 8 weeks in bed. In the period which follows, caution, good judgment and experience will dictate the wisest course to follow. As a last word, it may be said that many of them completely recover and live in comparative health and comfort for a number of years.

DISCUSSION

Dr. W. E. Darnall emphasized that the one thing necessary in making the differential diagnosis was to carefully go over every patient with symptoms referable to coronary thrombosis. The days of rushing the patient to the operating room in the presence of acute abdominal pain is past. With the aid of the clinician, the x-ray and the clinical lab-

oratory findings, many serious mistakes can be avoided.

Dr. H. S. Davidson stated that while everything that *Dr. Patterson* had brought out in his paper carried weight, every case was not so clear-cut and was often missed. The patient without general arteriosclerosis but with an arteriosclerotic coronary system is going to be missed, as is the low-grade diabetic without a pericarditis but whose interven-tricular system has been attacked. "To listen to *Dr. Patterson*," *Dr. Davidson* said, "it seems we should never miss a case, but it is not always so easy."

He mentioned having seen a patient, with a

group of other clinicians, in whom a diagnosis was very difficult to make; it was only after 2 or 3 days' intensive study that a differentiation was made in favor of gall-bladder disease.

Dr. S. Stalberg stated that he found morphine of great value in treating these cases. He also spoke of using adrenalin in cases where the blood pressure drops very low.

Dr. Patterson, in closing the discussion, said that he felt as *Dr. Darnall* did with regard to the complete and thorough studying of those cases with repeated abdominal pain, and that he realized this differentiation often took days of careful study.

OPPORTUNITIES FOR CO-OPERATION BETWEEN THE SCHOOL PHYSICIANS AND THE STATE INSTITUTIONS FOR MENTAL DEFECTIVES

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The School of Public and International Affairs of Princeton University was appointed by Governor Moore to make a survey of administration and expenditures of the State Government of New Jersey. In the Report—Chapter VII—The Department of Institutions and Agencies, the first sentence reads: "The work of the department of institutions and agencies deals with human lives—those persons who through poverty, disease or other causes have become the wards of the State." The last sentence of the first paragraph reads: "Reckless and indiscriminate cutting of budget requests may reduce the amount of money to be appropriated within a fiscal year, but it may entail huge costs to the State in the long run if essential services are curtailed or necessary planning for the future is made impossible." To this I would like to add, that the object of the State Institutions is to care for persons who for any reason cannot be cared for at home and to prepare them to return home if possible. By care, I mean in its broadest sense—medical, educational, social, etc.

The problem I want to discuss with you as

school physicians is, how we can coöperate to get better results in handling the mental defective child. As you know, I represent the Village for Epileptics. I have conferred with the superintendents of the Feeble-minded Institutions, and I hope by pointing out our various facilities and aims that you can use us to better advantage.

We do not consider the borderline case as our problem. Ordinarily this case is taken care of at home. It is true that it is a problem and we hope that in the very near future our state will have completed facilities at Holmdel to take care of this class along the same lines as is being followed in Pennsylvania at the present time.

We, in the State institutions, know that we cannot make normals out of mental defectives. We cannot make matrons nor executive housekeepers of our girls, but we can make cooks, housemaids, seamstresses, dish washers, scrub women, etc. The same is true of our boys. We cannot make college professors, bank presidents nor high-grade mechanics of them, but by recognizing their affliction and teaching and training them accordingly, we can make good janitors, housemen, mechanics' helpers, etc. The normal person can do any of these things

when the necessity arises, because he can adjust himself. However, it is impossible for the mental defective to make an adjustment so that he can carry out the higher mental activities no matter what emergency arises.

The epileptic problem is entirely different from that of the feeble-minded, and were it physically and financially possible to institutionalize all the epileptics in the State, I would not mention their return to their homes. Because of the convulsions and the various mental disturbances to which they are subject, epileptics cannot be expected to carry responsibility and must have more or less supervision.

These preliminary remarks might lead you to think that we neglect the academic training of our patients. I do not wish to convey such an impression. We believe that every child is entitled to at least an eighth-grade education if his mentality is such that he can acquire it. On the other hand, our chief object is to fit these unfortunates to become as nearly self-supporting as possible.

Judge John M. Rankin, of Iowa, recently made the following statements:

"A survey of the prison population of this country reveals that a great majority of the unfortunates therein are victims of arrested mental development.

"Since evil is more attractive to the normal individual than virtue, it follows that to the childish mind it is doubly so.

"I cannot help believing that it would be much more profitable to us to devote our time, money and attention in placing ourselves in position to measure the minds of juveniles and lead them into proper environment, than it is to devote them to institutions and methods of punishment of juvenile offenders after crimes have been committed.

"I am sure you will agree with me that many useful pieces of work may successfully be performed by an adult body even though that body is equipped with a 10-year-old mind.

"Thousands of children with minds which prevent them from advancing beyond the third or fourth grade in school, but who grow up to be physically strong men and women, could be guided into occupations which would enable them to be self-supporting citizens if taken in time, and with proper environment could be

saved from becoming inmates of penal institutions.

"With our craze for higher education, our compulsory school law, with all of our expensive equipment for training the mind, we lose sight of the fact that children are not like white sheets of paper to be run through the press and be finished exactly alike.

"Sooner or later the people will awaken to the cold fact that there is such a condition as arrested mental development, and that in such cases a far different course must be pursued than is followed with a normal child."

The fact that all children are not like "white sheets of paper" is being recognized by the medical profession and the educators. This applies as much to the normal child as to the abnormal. All children cannot master a task within the same time limit. However, the one who requires a longer time may retain the knowledge and apply it more advantageously than the other. Within certain limits the group educational system may not be detrimental for normal children, but it is not a successful method with the mental defective. Competition stimulates effort but it must be fair competition. Unfair competition depresses the poorly equipped competitor and frequently drives him out. The same thing is true when we try to educate the mental defective by holding him in a grade for 3 or 4 years and allowing the promotion of those better equipped mentally. After 2 years the defective decides that it is of no use, makes no effort, becomes immune to being called a "dumb-bell", quits, and derives no benefit from the time spent in the class. On the other hand, if the child is given a task which he can accomplish, he probably will be able to complete the 1 year's work in 4 years. If he can compete with children of his own mental level, so much the better. This is the greatest advantage of institutional training for patients. The child is conscious of the fact that he is as well or better equipped mentally than his associates. In order to accomplish the best results in the training of a mental defective it is necessary to recognize his condition and begin treatment early.

While mental retardation and epilepsy have been recognized for centuries, our real accom-

plishments are in the beginning. It is rather depressing to compare the accomplishments of our mental hygiene movement and our prevention of tuberculosis. A few years ago when patients developed tuberculosis they were practically doomed. Today, thanks to the publicity given to this disease and the funds obtained by the Anti-Tuberculosis Association through their Christmas Seal campaigns, lectures and other activities, clinics have been established. These clinics do not compete with the general practitioner but assist and help him to pick out the early cases of tuberculosis so that these patients can be treated, taught how to live and returned to their former homes to lead lives of usefulness. To be sure, their activities are curtailed. Nevertheless, they can live active, useful, happy lives because they have been taught to live with their affliction. One of the important things learned by them is that they are afflicted with tuberculosis, not bronchitis, laryngitis or a hundred and one names that can be given to the disease. They are told frankly what the disease is and its effect on their activities. They are shown methods of earning a livelihood.

When we are able to teach the family and the affected persons that mental afflictions are as much a disease as tuberculosis is a disease and that there is no more reason to be ashamed of a mental defective than of a physical defective, we will have gone a long way toward placing these people in society as useful, active, happy members.

Further, the Princeton survey in its report recommends the extension of our mental hygiene work. Probably you know that the State Hospital at Greystone Park has been very active in northern New Jersey with its mental hygiene clinic. The State Hospital at Trenton because of less financial support has not been able to do as much work. The new hospital at Holmdel has not been able to go outside of the hospital but does have a very active clinic in the institution and is always glad to consult with the physicians and examine patients referred to it. I know that you men, as school physicians, are not, as a rule, highly trained psychiatrists. Neither is it your business to supplant the family physician. On the other hand, physicians who have been in ac-

tive practice for a few years become fairly well versed in psychiatry. As school physicians you frequently become the family physician. Even though you are neither a psychiatrist nor the family physician it is important that you, as school physicians, be able to make recommendations to the school board so that in turn the family can be advised what facilities are offered to care for their child.

In this State at the present time we have 5 institutions caring for the children of school age. All of them are equipped with hospital and elementary school facilities. All are advantageously located with ample acreage for lawns, truck patches and animal husbandry. In addition to these, the various institutions are especially equipped to take care of their particular problems.

The North Jersey Training School at Totowa is intended to care for the higher type feeble-minded female. In addition to the equipment mentioned they have a vocational training system including a domestic science department, sewing room, etc. The school includes an excellent music department.

The Vineland State School cares for feeble-minded females of all degrees of mentality. In addition to the equipment already mentioned, they have an industrial building in which they train suitable cases for factory work, such as running knitting machines, etc. This kind of work helps to train individuals to factory life adjustment. They have a well-equipped school including a music department which has developed a band known over the State for its excellent performance.

The New Jersey State Colony for Feeble-minded Males at Woodbine cares for the idiots and low-grade imbeciles over 5 years of age. We cannot expect any marked results with this class. However, it is surprising to see a patient who appears to be on admission a drivel-ing, vegetated idiot, develop into an individual of clean habits taking some interest in his surroundings and being of some help in caring for his associates. The school work, of course, consists of very elementary academic and hand-work instruction.

The New Jersey State Colony at New Lisbon cares for the higher type feeble-minded male. They do more advanced school work,

their hand work is much further advanced. They pay particular attention to music and have developed an excellent band. Animal husbandry is being developed. They have one of the prize hog herds of the State. They are cleaning up their waste land, some of which has been irrigated and is producing excellent crops.

The New Jersey State Village for Epileptics at Skillman cares for the epileptic of both sexes. The only qualifications necessary for admission are that the patient must be over 5 years of age, a resident of the State of New Jersey, and an epileptic. Because of the various degrees of mentality found in epileptics—from the lowest grade idiot to the early case which is apparently of normal mentality—and the nature of the disease, our school equipment must necessarily be more varied and our hospital equipment more extensive. Our school department begins with sense training and carries the patients to the eighth grade if their mentality will permit.

I have purposely not mentioned the correctional institutions. I believe that the time is rapidly approaching when we will recognize the difficult child's troubles and send him to an appropriate institution for training before it is necessary to send him to a correctional institution for discipline. This procedure will go a long way toward enabling the child to adjust and relieve the odium of having served a court sentence.

When a child is first admitted to any institution, the first step is to determine his physical condition and start necessary corrective measures. The next step of importance is to determine his mental state. Then our real problems begin. We are all anxious for the child to carry on with his ordinary school work. However, we believe that when a child's mentality is such that he can be taught to repeat the multiplication tables parrot-fashion and to make a bed or wash dishes monkey-fashion, it is much more important to teach him to make a bed or wash dishes. No one will pay to hear the multiplication tables repeated but there is practically always a place where an individual can get board and lodging if he can wash dishes, make beds, or do any of the ordinary household duties.

We all take advantage of our lawns, animal husbandry, truck patch, general farm, laundry and mending rooms as educational facilities. These tasks are menial but if mastered will provide a means of obtaining food and lodging. It is not at all unusual for a family to object to having their child do this work and sometimes it is very difficult for us to convince them that it is important to prepare this child to do the things within the limits of its mentality. I have had mothers insist that they wanted their 15-year-old boy with a mentality of 7 devote his entire time to what they call school work so that he could be prepared to enter preparatory school when taken from the institution.

Now, with this picture of what we are trying to do, I want to tell you how to proceed with the least trouble to have a patient admitted to one of the institutions, in case you have a candidate. In the first place, the mental hygiene clinics are anxious to give you every assistance in determining the mental status of the patient. In order to avail yourselves of their services, simply write to Dr. F. Lovell Bixby, Director of the Division of Classification and Education, and he will send your preliminary blanks and make an appointment with the nearest clinic. Completely fill out and return the blanks at your earliest convenience. The clinics can care for about 8 patients a day, and you can rest assured that your appointment will be made for the earliest possible date. After your examination has been completed and the proper institution selected, your County Adjuster will gladly furnish you with commitment blanks and assist in getting the necessary Court order. The application is made by a responsible person. The physician's certificates should be made out in full. If properly filled out, these forms greatly facilitate the admission of a patient. It is not at all unusual to hear complaints that there is much delay after the application has been made, before the admission of the patient to the institution. There are several reasons for this. The most important is, that because of our overcrowded institutions it is frequently necessary to wait for a vacancy before the patient can be admitted. Some doctors fill out the blanks by making a check mark, others

start to write "yes" or "no" and continue to write "yes" or "no" as long as there is a blank space. It is impossible for us to determine the condition of the patient. We may have a vacancy for an idiot but not being able to determine whether or not the applicant is an idiot, we must delay the admission of the patient until further investigation is made. This means sending out a field worker or else requires a great deal of correspondence. All cases must have a Judge's order before admission. Seldom is there need for immediate institutionalization of feeble-minded cases. Therefore, final orders can be procured. With the epileptic, emergencies do exist where immediate institutionalization is necessary and patients are admitted on temporary orders. "Temporary order of commitment" is unfortunately worded; probably it would be better if called an "emergency order of commitment". The only reason for the temporary order of commitment is that the patient must be institutionalized immediately and the Court has not had time to determine the legal residence and financial status of the patient. In other words, the order is only temporary in the sense that a final order will be made as soon as the Court has had an opportunity to investigate. The family, the patient and the other interested parties frequently think that a temporary order means that the patient is committed for a temporary period of time.

Too frequently the patient is admitted without the family having any idea of what to expect. They immediately become dissatisfied and remove the patient before he has opportunity to become adjusted. If the family could be made to understand the nature of the institution, its aim, and the requirements of the patient, this unnecessary work could be avoided. We are always glad to show the families about the institution and to explain the various activities.

Our aim is to train the mentally defective to live useful, happy lives and to prepare them to live outside of the institution, if possible. In order to do this, they should be institutionalized early and kept through adolescence and early maturity. We believe that this procedure will have a four-fold result: (1) It will prevent a great deal of delinquency; (2) it

will give the permanent institutional patient an opportunity to adapt himself during the trainable age; (3) it will establish some means of contributing toward the self-support of the person able to leave the institution; and, (4) it will reduce to a great extent the number of minor crimes in the mentally defective adult.

I have tried to give you a picture of the institutions. In order to make this picture more complete, I extend to you an invitation to visit the Village at your convenience either individually or in groups. I know that the superintendents of the other state institutions will be glad to have you visit them, also.

DISCUSSION

Chairman Ireland: The need for the information you have given us is very apparent to one in my position. School physicians and, I suppose, principals more than any other class, are constantly writing us: "What shall we do with this child?" Nurses are in that position because they are the ones in contact with the homes. A few years ago, during our county institutes for nurses, we presented these rules for admitting children to the state institutions.

We were made conscious, as Dr. Renner read his paper, of the tremendous underlying social problem in this whole matter, the increasing necessity for institutions, and the increasing amount of emotional instability and mental defectiveness. That is a challenge to us in all lines of health work.

As I have watched this situation develop, we started with ordinary medical inspection; then the health program broadened out, largely a physical health program; then came mental hygiene, first outside of the school, and then gradually introduced into the school. Finally came vocational guidance, trying to guide the pupil into the right occupation. Now we call it student personnel, not merely vocational guidance, by which we try to fit pupils for all phases of life. This paper of Dr. Renner's brings to us the tremendous scope of this guidance work; it has to do with the needs of all kinds of children and all phases of society.

It is not for me to predict what is going to happen in this great social scheme of ours. However, I think all of us working with children are conscious of the great need for what we know, inadequately perhaps, as mental hygiene, personal adjustment, psychiatry, and psychology. I know from the school side that school administrators and boards of education are becoming increasingly conscious of this discipline problem, this behavior problem, the poorly adjusted child, and of the opportunity which is ours for taking these children and fashioning them, each according to his individual needs.

We are very grateful to you, Dr. Renner. You have given us the sort of information we all need to have.

HYPERPLASTIC ETHMOIDITIS

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In the time allotted to me, no attempt will be made to give a theoretical dissertation, but rather to bring this subject up to date with regard to diagnosis and complications.

Chronic catarrhal inflammation of the ethmoid labyrinth—also known as hyperplastic ethmoiditis—has been proven by Roentgen ray to be a rarefying osteitis with slow and gradual absorption of the bony partitions of the ethmoid capsule. As a result of this inflammation there is a corresponding thickening of the lining membrane of each cell involved.

The inflammatory reaction in osseous tissue is usually expressed in the form of caries, necrosis, or sclerosis, these various changes being influenced by the severity of the inflammation and the density of the bone. If cancellous or cellular, as is the ethmoid, caries and sclerosis generally develop with the formation of polypi and granulation tissue, which are inflammatory in origin. Hajek, who studied this process microscopically, has established the relationship between mucous membrane inflammation and hyperplastic osteitis. According to this investigator, chronic hyperplastic inflammation starts with a cellular infiltration of the superficial layer of the mucous membrane and—dependent upon the duration and intensity of the inflammatory process—spreads beneath the basal membrane. Later, the whole depth of the mucous membrane and the medullary spaces of the ethmoid capsule become involved.

The pathologic products of ethmoid and sphenoid infection may be absorbed by continuity and contiguity of tissue, or by lymphogenic or hematogenic routes. When any one of these routes is invaded, persistence of its evil effects is the rule, even for a considerable time, after the original source of such infection has been eradicated.

The pathologic changes usually occur in the order here indicated: Primarily there is a phlebitis, followed by a thrombophlebitis and, sub-

sequently, by a thrombosis. Disintegration of the infected thrombus results in numerous emboli; these in turn may be transported through the medium of the blood-stream to almost any part of the body.

There are certain phases of the relationship of the eye to the paranasal sinuses that are apparently well understood, and therefore call for little or no discussion at this time.

The ocular complications attending ethmoiditis and sphenoiditis may be divided, arbitrarily, into 3 distinct groups:

(1) A cellulitis, an abscess, a phlegmon, and an edema occurring within the orbit, these being generally caused by ethmoid and sphenoid infection.

(2) A retrobulbar neuritis and a papillitis—conditions which may be due to infection in these regions.

(3) There is a conjunctivitis, a keratitis, an episcleritis, a uveitis, etc. The conditions in this group are never caused by ethmoiditis and sphenoiditis.

Considering the frequent occurrence of sinusitis, the relative infrequency of these complications must not be overlooked. There exists, in fact, a difference of opinion among ophthalmologists as to the etiologic basis of the sinuses for these manifestations. The most interesting phase of this subject is the important relationship of the ethmoid and the sphenoid to retrobulbar optic neuritis. The ophthalmologist plays an important part in assuming the burden of diagnosis and of distinguishing between intracranial and intranasal etiology.

The osseous optic canal normally affords great protection to the optic nerve, but its unyielding wall may cause a constriction sufficient to produce atrophy of the central fibers of the optic nerve, if the nerve sheath becomes edematous or swollen. Anatomists estimate the average diameter of the optic nerve to be 3.5 to 4.1 mm., and the normal diameter of the optic canal 4.5 to 5.17 mm. Should a nerve 4

mm. in diameter be placed in a closed osseous canal of 4.5 mm., it is obvious that a slight swelling of the nerve sheath might cause sufficient pressure to produce atrophy.

Papilledema arising from infections is usually unilateral, transitory, and of moderate degree, i. e., 2 to 3 diopters, and at times as high as 8, with a sudden loss of vision. The condition as observed in pituitary disease, brain tumor, and multiple sclerosis is of slow onset and is usually attended with a corresponding loss of vision. According to Uhthoff, the optic nerve is involved more frequently in multiple sclerosis than in locomotor ataxia; with the exception of brain tumor, more frequently than in any other disease of the nervous system. The pathologic lesion which causes this form of amblyopia, according to Uhthoff and other observers, is an interstitial neuritis of the papulomacular fibers located more centrally within the optic nerve.

The disturbances in the visual fields which occur in multiple sclerosis are central scotoma, either relative or absolute. There may be peripheral alterations or concentric narrowing, leading sometimes to blindness which, however, is rarely permanent. The optic nerve has a bony wall of thickness which varies from .2 to 2 mm. and is usually 2 to 5 mm. distant from the anterosuperior portion of the sphenoid sinus cavity.

The brain and cord, in multiple sclerosis, contain widely distributed plaques of degeneration, and the optic nerve, which is a prolongation of the brain, is affected in about one-half of all cases. Morphologically the nerve fibers lose their myelin sheaths, and the axis cylinder, though naked, does not break up, as in tabes, nor is their conductivity destroyed. The lesions are irregularly distributed and any of the optic nerve fibers may be involved; at times, only the axial bundle.

Both optic nerves are usually affected in cases of multiple sclerosis. The lesions within the nerves, however, are so unequal in their distribution that atrophies recorded clinically affect approximately one nerve in 75% of the cases. Exceptionally, neuritis precedes atrophy, but the majority of cases are atrophic from the first. The ophthalmologic picture in multiple sclerosis corresponds to the anatomic dis-

tribution of plaques. The nerve may show atrophy in the temporal side only or a diffuse incomplete blanching may exist.

Minute multiple central scotoma for red and white is a frequent early symptom; later annular scotomata may develop and, in some cases, scotomata may develop without visual changes in the nerve.

Frequently there is a complete paralysis of one or more muscles of the eye, the sixth and the third nerves being most generally affected. Nystagmus in fixing the eyes on an object in a lateral position is a very important symptom when present. The optic nerve may be affected years before other symptoms of multiple sclerosis are sufficiently pronounced. Multiple sclerosis does not lead to complete blindness and it is characteristic in this disease for the ocular disturbances to subside and to be followed by temporary recovery. Temporal blanching of the nerve should always suggest multiple sclerosis, although it does occur in other toxic conditions. If other common causes of central scotoma can be eliminated, diminution of abdominal reflexes warrants a diagnosis of multiple sclerosis, even in the absence of all other symptoms.

Herzog observed definite sinusitis in 4 out of 28 cases of retrobulbar neuritis; Moller found it in 4.5% of the cases; Lange in 3.5%. The late Dr. White stated that his first 17 cases were all considered due to sinuses, while later experience led him to believe the sinuses were only one of the foci to be considered. In a more recent experience with a series of 60 cases, Dr. White found the teeth and tonsils responsible for 70% of retrobulbar neuritis, while only 6% showed signs of ethmoiditis. Le June, Bradley, Peter, Oliver Crowe, Stack, Crane, and many others reported cases in which the etiologic importance of sinusitis to retrobulbar optic neuritis was considered proven. On the whole, however, the general impression of these authors was that it was one of the important causes of the condition. Scheerer and Maier, reporting a series of 203 cases over a period of 8 to 9 years, found 80% definitely caused by multiple sclerosis; 6% of the number were alcoholic; 11% were of unknown origin—leaving only 3% due to retrobulbar neuritis from sinusitis.

The search for an explanation of certain cases of retrobulbar neuritis has stimulated investigation of dehiscencies at autopsy. It is worthy of note that in the majority of dehiscient cases examined postmortem, there had been no history of optic neuritis; and that, in a number of autopsied retrobulbar cases, dehiscencies were not observed in sufficient numbers to support the view that it is one of the important conditions to be classified in the etiology of retrobulbar neuritis. Dehiscencies may vary from pin-point size to a complete exposure of the optic nerve within the sphenoid sinus.

Dehiscencies of the *sphenoid* have been observed to extend to the hypophysis, the brain stem, the pons, the basilar artery, the optic chiasm, the cavernous sinus and internal carotid, the nasopharynx, vidian nerve, gasserian ganglion, the optic nerve; the oculomotor, the trochlear, the abducens, and either of the three divisions of the trigeminal nerve. Those of the *ethmoid labyrinth* have been seen to extend to Meckel's ganglion, the frontal and maxillary sinuses, the dorsal orbit plate and the lachrymal sac.

In consideration of the numerous dehiscencies presented, it is logical—if one is partial to the view that sinus infection is the source of the trouble—to expect to find other neural disturbances in subjects with retrobulbar neuritis. It is not a common coincidence to find either the motor, ocular, the trochlear, the abducens or, in fact, any of the subdivisions of the trigeminal nerve, affected in the usual type of retrobulbar case. It can readily be seen that the line of least resistance is by way of the weakened and unprotected space. An irritant, whether it be toxic, bacterial, anaphylactic or putrescent, can readily invade the neighboring area and produce a neuritis of any exposed nerve.

Neurosurgeons are apt to take the opposite view, doubting the rhinogenic origin of many of these cases. In recent years, attention has been directed to cases of multiple sclerosis in which the ophthalmologic picture simulates that observed in retrobulbar neuritis. The neurologist is indispensable in rendering his assistance.

A thorough physical and neurologic exam-

ination should be undertaken in every case. When the sinuses are negative, the teeth and tonsils should be inspected and, if infected, should be removed. In the usual case, a history of the onset of the amblyopia is characteristic either of its nasal or central origin and is easily recognized; in the atypical case where definite nasal pathology coexists, diagnosis is more difficult.

In one case observed by A. Gathur, a bilateral ethmoiditis was present, associated with a bilateral retrobulbar neuritis. Following enteration of the ethmoidal labyrinths, an improvement in vision occurred. Later, it was shown that the ocular manifestation represented the onset of multiple sclerosis. According to recent observations, this is rather common.

The presence of pus in the sinus was formerly considered by rhinologists as sufficient explanation for most of the disturbances about the optic nerve. Later investigations have changed this view considerably, for while this may undoubtedly be the cause in some instances, it is not invariably so. The publications of Sluder and Wright pertaining to the anatomic studies of sinuses, so influenced the opinions of rhinologists of today, that they can no longer give a negative report when purulent fluid and polypoid hyperplasia are not observed in the nose.

The fact that retrobulbar neuritis may be an early manifestation of multiple sclerosis should not be forgotten. According to Marx, it may develop in a certain percentage of cases from 1 to 7 years after an apparent recovery.

CONCLUSIONS

In conclusion, it is my opinion, that:

(1) The retrobulbar optic neuritis and papillitis are the result of sinus infection, and that the ethmoid and sphenoid are usually involved.

(2) The frequency of this association has no doubt been over-emphasized.

(3) Multiple sclerosis appears to be the most common cause of retrobulbar optic neuritis.

(4) Following surgical intervention in sinusitis, the restoration of vision in retrobulbar

optic neuritis should not necessarily rule out multiple sclerosis as an etiologic factor; the recovery of vision may perhaps be attributed to the remission of symptoms common to this disease.

DISCUSSION

Dr. Raymond C. Creasy (East Orange): A study of the European literature served to impress me with the unusually high percentage of multiple sclerosis apparently responsible for cases causing retrobulbar optic neuritis. In America today, the percentage recognized is very much lower. The fact that multiple sclerosis has been observed to have quiescent periods of from 1 to 7 years before again showing signs of progressive degeneration, makes the condition a more complex problem. However, with many keen observers among the professional men of America, it probably will not be many years before we recognize the true relationship of retrobulbar optic neuritis to paranasal sinus infection.

The etiology of multiple sclerosis is as yet theoretical—many theories are offered. One is, that there is a change from the normal metabolic chemistry of fat tissue, this taking place in the liver, and that this chemical change may basically be dependent upon some focal infection. It is in this respect that the ethmoidal infection may play a very important rôle. We may in comparison say, that fat metabolism is to multiple sclerosis what sugar metabolism is to diabetes.

The paranasal sinuses are of no less importance than is the petrous pyramid of the temporal bone, which only recently has been dealt with successfully.

It is my impression, from the number of cases I have observed, that the lymphatic and Haversian canal systems are the first to become involved in a local infected area, and it is by tissue continuity and contiguity, that destructive changes are apparent.

I am sure it has been the experience of most of us in certain cases, where the patient has an ethmoidal infection and a vision of 20/100 or less, that following repeated shrinking of the nasal mucosa with suction, an immediate improvement in vision has been observed and, in a number of instances, normal vision restored. In these successful cases, operative intervention should never be recommended.

It would be of great value in making a differential diagnosis if more charting of visual fields were taken at regular intervals. It is most important to have the same person, where it is possible, record the charting at intervals, corresponding to the rate of the suspected visual change.

Every one attending this State convention should consider it his duty to contribute something toward the solution of this problem.

Dr. G. E. Pauley (Queens Village, Long Island, N. Y.): Dr. O'Brian's paper deserves much credit,

as this subject is very hard to find anything about in the textbooks. I know, because I have tried to read up a little bit on it myself. All the data given by him on hyperplastic ethmoiditis, he has had to find in papers by different writers, which has made it quite a colossal piece of work.

The present-day hospital records show fewer and fewer radical sinus operations; each year there are fewer Killian operations or radical antrum operations, but this is not true of the ethmoid sinuses. There are just as many ethmoid operations done today as in previous years and probably more. I think the reason for this is, that the situation is forced on us by the ophthalmologist. Take a case that is losing vision. When the medical man examines the patient, he finds the kidneys all right, the chest all right, everything negative; and then it is up to the rhinologist. When he looks into the nose and throat, he just "wishes" to see some ethmoid involvement.

The first thing we ought to see, before calling it sinus trouble, is some pus. We may see a little bit of mucus and say, "It must be pus!" The patient may be losing vision, the ophthalmologist's hands are tied; he doesn't know what to do about it, so a double ethmoid operation is performed. Fortunately, in many cases the vision improves. In other cases, operation doesn't seem to have any effect. So, I wonder, if we are not a little over-anxious to operate on ethmoid conditions.

We say we do an ethmoidectomy but I think, fundamentally, that is a wrong statement, because we never get all the cells. Sometimes I feel, when we do an ethmoid operation and this sinus is really at fault, that we possibly miss 3 or 4 cells with pus in them that are the actual foci. Afterward, we get the blame for lack of results; the operation has been done, the patient isn't any better—possibly we haven't done it well enough. Particularly in retrobulbar neuritis, the sinus findings are slight even when they are the causative factor. Very seldom does one find a case of profuse nasal discharge of pus with headache. On the other hand, it is usual to find a patient who uses one handkerchief a day on the nose, who claims he hasn't any headache, and there is very little involvement to be seen in the nose.

The x-ray picture is a decided help in diagnosing whether there is ethmoid trouble or not. I find, however, that x-ray specialists differ as to its value. If one takes x-ray pictures of ethmoids in this part of the country, we will find 95% who live around this region have ethmoiditis.

The unfortunate part of a complete ethmoidectomy is the danger of it. I feel that any man who has done a great number of ethmoid operations has at some time or other had an unfortunate result. That is a chance the patient takes. I do not think it is a minor operation. I think it is a very severe major operation. It is certainly an area that we need to know much more about and the relation it has to eye conditions.

We should compliment Dr. O'Brian on the paper he has presented. He has done much work to ferret out things we should know about. In future years, possibly more will be revealed to us.

Dr. O'Brien (closing): I have very little to add. I agree that the dangers one encounters when dealing with the sphenothymoidal labyrinth because of its intimate relation to the brain and meninges. I am of the opinion, however, that radical surgical measures should be instituted in almost all cases where field and color changes are observed

associated with a sphenothymoiditis, and a normal abdominal reflex.

I believe that probably multiple sclerosis is responsible for these ocular changes in 50% of the cases, and that sinus infection shares the greater part in being responsible for a good portion of the remaining 50%.

THE ETIOLOGY AND TREATMENT OF ACNE VULGARIS

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Acne vulgaris is one of the commonest of all skin diseases. Its usual onset is at the time of puberty and its incidence is slightly greater in males than in females, contrary to general belief. The importance of acne lies in the fact that it is a disfiguring disease and may cause profound emotional disturbances which are not easily remedied. Young men and particularly young women who are afflicted with acne frequently suffer from attacks of melancholia, depression, and inferiority complexes. They are handicapped tremendously in their formative years and may carry the scars of emotional disturbances throughout life. It must be remembered, therefore, that when dealing with acne, we are not concerned with a skin disease of small consequence, but one of considerable importance both to the individual and to society.

Acne, beginning as it does at puberty in most cases, may be looked upon as the local manifestation of a general disturbance. To my mind, acne rests primarily upon an endocrine basis. At a time when all the functions of the organism are undergoing a change from childhood to puberty, when pubic and axillary hairs appear, when the voice changes, when the breasts assume a rounded form in the female, when the thyroid enlarges, when gonad development appears, there is a concomitant intensification of the functions of the sebaceous glands of the skin. When the changes in body economy occur gradually and normally, when there is little or no maladjustment of that deli-

cate endocrine balance, acne is not likely to develop. But if the balance be disturbed by intercurrent illness, constipation, anemia, improper diet, or poor hygiene, then the skin is likely to suffer. An increase in the oil secretion of the sebaceous glands takes place together with a hyperkeratosis of the mouths of the follicles. Thus the basis is laid for the formation of comedones, the *sine qua non* of acne. We do not know whether the sebaceous secretion is altered in quality, quantity, or both. We know that the secretion sooner or later becomes stagnant, is held in the gland by the hyperkeratosis, and finally assumes the character of a foreign body. The ever-present inhabitants of the skin surface and sebaceous glands, the pus cocci and the acne bacilli, soon find a happy medium for their proliferation and change the comedone into the papule and the pustule. It is only fair to mention here that some observers believe that the acne bacillus is the primary cause of acne. They maintain that this organism causes a chemical change in the normal sebaceous secretion, making it act as an irritant, and thus produces an inflammatory reaction. Others believe that alteration in the sebaceous secretion takes place first and that the organisms are secondary invaders. The production of pus leads to the formation of scar tissue, for wherever there is pus, there will one also find tissue destruction. Whether this tissue destruction is superficial or deep determines the extent of scar formation. This tendency to scar formation varies in individuals. Some cases with deep pustulation may show little scarring,

while others with comparatively mild acne may be scarred to a considerable extent.

Many cases of acne tend to clear up spontaneously after the twenty-fifth year of age. Some individuals may clear up before that time *pari passu* with the establishment of normal sexual relations. Does not this tendency to spontaneous involution lend weight to the theory of endocrine imbalance as the cause of acne? Or, on the basis of the germ theory of causation of acne, is it not possible that a local immunity develops which produces an unfavorable soil for the growth of the organism? These questions are merely speculative at present. There is an interesting corollary in the matter of tinea capitis, which is fairly common before puberty, but is almost a medical curiosity after puberty. Normal sexual activity, by speeding up certain metabolic functions, probably hastens the establishment of the endocrine balance and gonad development. On the other hand, many cases of acne do not improve after marriage, nor even as late as the thirtieth year of age. These may be instances of over-stimulation, thus throwing the mechanism out of balance, or the abnormal processes may have continued so long that the capacity for proper interplay of the balancing forces is exhausted, or other causes of derangement supervene.

There are also many cases of acne occurring for the first time in women in their late twentieth or thirtieth years. These are often associated definitely with menstrual abnormalities as is evidenced by the improvement in some of them under glandular therapy. Lester Hollander collected a series of cases of acne in persons between 30 and 42 years of age. In every case the social status could be classed as unmarried or widow. The question arises as to whether or not the pelvic irritation caused by stagnation in the reproductive organs is sufficient to produce a hyperstimulation of the sebaceous and pilosebaceous glands to abnormal activity without the involvement of the endocrine system.

Bruno Bloch looks upon comedone formation in acne as a physiologic manifestation of the organism at the time of puberty. He divides acne into 2 phases; first, that of comedone formation, and second, an inflammatory

and suppurative process on the basis of infection. Bloch attempted to ascertain exactly when and how often acne makes its appearance, and what relation it bears to puberty, especially to the appearance of secondary sex characters such as pubic and axillary hairs, and menstruation. His figures are extremely interesting and almost startling. He examined 2136 girls between the ages of 6 and 18 and 2055 boys between 6 and 19. Those who had acne, ranging in severity from the presence of a few comedones to numerous papules and postules, were 1273 or 59.6% of the girls, and 1408 or 68.5% of the boys. If the cases having only a few comedones are not counted, 8% of the females and 20% of the males had true acne, or 14% of 4191 cases. In other words, every twelfth girl and every fifth boy in his series had true acne. He correlated the cases of acne with the presence of axillary or pubic hair or menses and found that a greater number of cases occurred when these secondary sex characters were present than when they were not present.

In an attempt to determine the hereditary and family background of acne, Stokes and King analyzed 143 cases of acne vulgaris and 100 controls. They found that acne is 26 times as frequent in the parents, and twice as frequent in the siblings of persons with acne, as in those persons who have never had acne. They were careful to point out that this does not establish acne as an hereditary disorder, but that it supports the suggestion of a background within the family. It is their impression that the pyogenic complication of acne; or the tendency to pyogenic infection is the important familial influence.

Consider some of the conditions which may aggravate acne or change the comedone phase into the pustular phase. These are constipation, secondary anemia, high carbohydrate diet, foci of infection and poor skin hygiene. I believe that these time-worn ideas have been given too much etiologic significance in the past. While they may be of considerable importance in making acne worse, they do not appear to be of primary etiologic importance. Constipation, anemia, focal infection and improper diet have their place in lowering the patient's resistance to infection. Too much

carbohydrate in the diet, for example, may work harmful effects in either of 2 ways: (1) by furnishing an enriched culture medium for the growth of organisms or (2) by favoring fermentation in the intestinal tract.

Many studies have been made on sugar metabolism in acne. These have been directed chiefly to determination of the sugar content of the blood. Schwartz, Highman, and Mahnken in 1916 were the first to report hyperglycemia in acne vulgaris. At the same time Pels reported a similar group of cases in which he did not find hyperglycemia. Strickler and Adams found that about 15% of acne patients exhibited a hyperglycemia, but that since a fair percentage of normal individuals at times also showed hyperglycemia, they concluded that acne vulgaris is not characterized by an increase in blood sugar. They also found that changes in blood sugar in individual cases over periods as long as 3 months did not coincide with clinical changes for better or for worse. Tauber recently wrote that in direct opposition to statements in the literature that common disorders of the skin are associated with hyperglycemia, he found almost without exception that the blood sugar was normal and that in furunculosis the reverse of hyperglycemia is the rule. To make his statements more striking he treated a number of cases of furunculosis with high carbohydrate diets and intravenous injections of glucose and found this therapy almost a specific in the cure of furunculosis.

In some cases of acne, gastro-intestinal disturbances may be found. Constipation and flatulence are the usual symptoms. Cunningham and Lunsford, in a study of 2974 cases of acne in women at the University of California found that 246 or 9.6% complained of constipation. In a control series of 3170 cases in which acne was not present, constipation was listed in 298 or 9.4%. Constipation, therefore, when present may be considered as merely an incidental factor in acne. In a recent x-ray study of constipation Kantor found that in 20% of a large series of cases, patients gave a history of constipation when they actually were not as shown by roentgenograph; in 12% the findings were reversed. It thus appears that many people think they are constipated when they are not. Schwartz found

in 60 cases of severe acne that 11 or 18% showed no evidence of protein putrefaction or carbohydrate fermentation, 22 or 36% showed protein putrefaction, and 27 or 45% showed carbohydrate fermentation in stool examinations. It would seem, therefore, that while a patient may or may not be constipated, intestinal indigestion may still be present.

Improper skin hygiene is another factor which may aggravate some cases of acne. The use of the wash cloth, the application of greases and creams, and picking at lesions all are to be condemned. The washcloth frequently becomes the inoculating agent for pus organisms from one portion of the skin to another as pustules are ruptured during its use. Greases and creams, besides being excellent culture media for organisms, assist in blocking the mouths of the sebaceous glands and thus help to increase comedone formation. The tendency of acne patients to pick and squeeze pustules and comedones should be discouraged as it is usually done in an insanitary and unskillful manner. The improper expression of comedones and pustules causes an increase in scarring and favors infection.

From present knowledge there does not seem to be any way of preventing an individual from acquiring acne vulgaris. Eunuchs are said never to have acne, but I do not believe that we would want to go so far as to make eunuchs of all our boys and girls to forestall the development of acne. I expect some future developments in endocrinology which will greatly aid in controlling and treating acne. For the present, then, we must content ourselves in utilizing to the fullest extent the modern methods of conventional dermatologic treatment. Bearing in mind that acne is due to a disturbance in the sebaceous gland activity of the skin, we may divide the treatment into constitutional and local methods. To secure best results, a combination of both should be used.

As some patients are made worse by too much carbohydrate in the diet, this item should be restricted. Many cases, however, will give a history of having been on a carbohydrate-restricted diet for some time before consulting a physician and will claim they have not improved. These cases need not be further re-

stricted. Again, there are some acne patients who are underweight and below par physically and need more carbohydrates. Common sense should be the guide in determining the diet. Text-book methods should not be too closely followed as each case must be studied as an individual problem. In general, all measures should be taken to improve the patient's general condition and resistance to infection. Foci of infection should be removed, constipation should be corrected, anemia combatted, and intestinal fermentation corrected by suitable diet. If there are menstrual or other manifest endocrine disturbances, an attempt should be made to rectify them. It is a common belief that ovarian and pituitary substances when taken by mouth are ineffective, but I have found by actual use that the products of at least one drug concern are potent when orally administered.

In the local treatment of acne, sulphur, resorcin, and salicylic acid in the form of lotions and ointments have been used for many years. These substances cause exfoliation of the skin and exert a more or less antiseptic action. Some cases of acne can be cleared up by the judicious use of these agents, but their action on the whole is uncertain and time-consuming.

Vaccine therapy has had enthusiastic supporters, but is chiefly useful in some cases of the deep pustular type of acne. Vaccines have no effect on the comedones or on the activity of the sebaceous glands, but may be used as an adjuvant to other treatment in selected cases.

Bloom in 1929, reported a series of 13 cases treated by intravenous injection of a 10% solution of calcium chloride. These were given in 10 cc. doses 3 times a week for several months. Several cases responded well to this treatment, even to the eradication of comedones and the diminution of oiliness. No report has yet appeared as to the lasting effect of this form of treatment.

Ultraviolet radiation frequently will produce an improvement in acne, but its action is merely temporary and recurrence is the rule. Rapid, temporary improvement may be obtained by producing a severe reaction followed by desquamation. Some types of acne, however, get worse under such therapy. The irri-

tation produced by the burn occasionally causes an increase in the amount of pustulation.

None of the methods of treatment so far mentioned can be compared to the results produced by superficial x-ray therapy in acne. The x-ray treatment of acne is used by practically all dermatologists. Its proper use requires care, skill and good judgment, with a properly calibrated and functioning machine. When properly applied by a dermatologist, x-ray treatment of acne is safe and satisfactory. It should be emphasized that no one but a properly trained physician should use x-ray in the treatment of acne. Anyone can be taught to operate a machine, but only the dermatologically trained eye can interpret the changes in the skin which require alteration in the dosage, change in the time interval between treatments, or cessation of treatment.

X-rays are used in acne because they inhibit glandular activity and aid in the absorption of infiltrated areas. It is known that the most active cells are most susceptible to radiation. The actively secreting cells of the sebaceous glands are sometimes stimulated to greater activity by the first few doses of x-ray, but later their activity is inhibited. Lymphocytic cells, which comprise most infiltrations, because of their radiosensitivity are disintegrated and become absorbed.

When the hyperactive glandular elements of the skin are inhibited and the hyperkeratosis corrected, the comedones and papules gradually disappear, the skin becomes less oily, and the acne is cured. This happens in about 90% of the cases treated. In about 5% to 10%, recurrences of a few papules or comedones are noted, but these can usually be relieved by a few extra treatments.

There should be no hesitancy in the judicious use of a modality which offers such excellent results in a chronic and disfiguring disease such as acne; but there has always been considerable discussion as to whether the x-ray increases scarring in acne. Recently Niles in a study directed towards this question gave 40 patients an average of $12\frac{1}{2}$ weekly exposures of one-quarter of a skin unit to one side of the face, and no x-rays to the other side. He found that the scars were equal on

both sides in 32 cases, more pronounced on the untreated side in 5, and greater on the treated side in 3. He concluded that the amount of scarring after acne was directly dependent on the severity and duration of the disease and the tendency of the patient's skin towards scar formation. The x-ray seems to have no in-

fluence on this tendency. We constantly see patients with more or less scarring who never have had x-ray treatment, and Niles' study apparently proves that the x-ray does not produce scarring when properly used. The sooner effective treatment for acne is started, the less scarring will result.

THE TREATMENT OF PAROTID TUMORS WITH ROENTGEN RAYS AND RADIUM

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An attempt has been made to evaluate roentgen rays and radium in the treatment of parotid tumors, particularly the malignant growths.

Such data seem especially important in lieu of the general surgical experience of a frequent tendency of the benign mixed cell types of tumors to recur. These recurrences or the development of new tumors have been successfully managed by repeated surgical excision even when they were noted to occur immediately, or as long as 10 to 15 years after operation. In a small percentage of cases recurrences were clinically and histologically malignant.

The question of some possible value from radiation is of further importance because it is not always possible to eliminate the question of malignancy even in frankly benign tumors—clinically and histologically.

There is much evidence to warrant surgical extirpation for frankly benign parotid tumors, but very little encouragement from the surgical results of malignant tumors, particularly when the clinical diagnosis of malignancy is obvious.

The published statistics of surgical results for malignant parotid tumors are so gloomy that an attempt to improve these results with roentgen ray or radium treatment should be given much encouragement.

Radiation procedures are conservative and can readily be adjusted to the physical tolerance of elderly individuals. Up to now there has been no superiority demonstrated for high-voltage roentgen rays as against radium packs or interstitial radium with platinum or steel needles or gold seed radon implants for the treatment of malignant disease.

Theoretically radiation should offer good possibilities of improving the end-results of parotid tumors. The histologic character of poor cellular differentiation points to a low-grade type of malignancy which is very radio-resistant. There is some evidence to indicate that a small percentage of these malignant parotid tumors are very highly cellular and therefore very highly radiosensitive.

The cellular differentiation of a parotid tumor is probably governed by the known duration. The surgical results have been decidedly better when growths have been of long duration—5 to 25 years or more. A slowly growing tumor over a period of years usually maintains benign characters, though not necessarily. The prognosis is less favorable for the rapidly developing tumors of short duration.

Patey studied 55 cases to establish a histologic classification according to their cellular differentiation. Certain types of highly cellular tumors showed a tendency to recurrence. The prognosis of removal of the encapsulated recurrence was proportional to the expectancy of the original tumor; but an infiltrating recurrence is more difficult to eradicate and the prognosis is correspondingly worse. Patey was

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not able to demonstrate any evidence of change of histologic type in recurrences. He suggests that a combination of surgery and radium should offer the best method of treatment in the majority of cases of mixed cell parotid tumors. For recurrences of the infiltrative type, radium would seem to be the method of choice.

Benedict and Meigs submit an analysis of 225 parotid gland tumors. They believe that the treatment in practically all cases should be operative. They feel that the chief value of radium or x-rays is in the treatment of recurrent malignant tumors, and palliative treatment for the advanced cases. They are not willing to submit conclusions about the results of 16 cases that were treated surgically in conjunction with radiation.

Benedict and Meigs observed that the surgical prognosis for carcinoma of the parotid is bad. Of 30 proved cases of carcinoma treated by operation, there was only 1 survivor. The duration of life after operation averaged less than 2 years. They think that radium prolonged life but did not cure the disease.

Berard and Creyssel analyzed the results of radiation for malignant parotid tumors; of 7 cases, 2 survived—3 and 6 years respectively. Twelve cases were operated upon and then given intensive high-voltage roentgen-rays. Of these 12 cases, 5 are clinically well—2 for 18 months—and 3 have been followed for 5 to 6 years.

Burrows, Wakely and others are of the opinion that all cases of mixed parotid tumors should be regarded as potentially malignant. The experience of the Manchester District Radium Institute indicates that combined operation and radium therapy is the method of choice and that interstitial radiation seems to offer quite as good results as operation plus radium.

Burrows reports results obtained in treating 16 patients as follows: surgery and radium, 8 cases, 8 cures; interstitial radium, 5 cases, 4 successes, 1 failure; external radiation alone, 3 cases, 1 success and 2 failures.

Meritt believes that combined surgery and radiation are superfluous and that the treat-

ment of mixed parotid tumors is especially a radiologic problem. He found that small encapsulated tumors respond as readily to radium seed or needle implantations as to excision.

Causse notes the frequency of recurrence of these tumors which at operation were apparently found to be encapsulated. Because 25% of such tumors recur, and because of the difficulty of eradicating an infiltrating and degenerating tumor, radiation, alone or in conjunction with surgery, has been tried. Causse recommends surgical extirpation followed by surface applications of radium.

Quick and Johnson are of the opinion that if a case is favorable for excision it is likewise favorable for radium therapy, and the latter does not predispose to recurrence or to metastasis. In carcinoma of the parotid, radium alone affords a reasonable hope of control or cure, and should be the agent of choice on account of the usually acknowledged surgical failures.

Ewing considers radium of much value, admitting, however, that after surgical interference encapsulated growths do not as a rule recur, but that others are very prone to return at once or after an average interval of $2\frac{1}{2}$ years.

There is still considerable controversy as to how much benefit is actually derived from radiation, especially as a post-operative procedure. The histologic diagnosis of malignancy can very often be challenged because the clinical course of many cases diagnosed as malignant microscopically is against such an interpretation. Conversely, many microscopic reports of benign mixed cell parotid tumors are confused by strong clinical pictures of recurring malignant growths that terminate fatally.

McFarland does not believe that the microscopic study of mixed tumors offers any criteria of prognostic value. He finds little evidence to support the statement that mixed tumors undergo "carcinomatous degeneration". He submits a wealth of clinical data with careful and complete final notes that justify the conclusion that mixed tumors are inherently benign, but commonly recur after excision, and if frequently disturbed become locally destruc-

tive and invasive, without giving metastasis. His clinical research reveals abundant evidence to support the surgical treatment of benign and malignant parotid tumors.

McFarland cites illustrations of clinically benign tumors proven histologically to be malignant without post-operative recurrences for 5 and 10 years. He also reports instances of carcinomatous changes in antecedent recurrent mixed tumors but with subsequent clinical courses of recurrences over a period of years which is against the original diagnosis of carcinoma.

It is obviously impossible to establish histologic criteria for benign or malignant differentiations in all cases. There are apparent contradictions of microscopic findings and post-operative developments.

It is fair to assume that the good surgical results, for the most part, represent ideal material from the standpoint of good localization of growth with early malignant changes. The infiltrating type of neoplasms that clinically were frankly malignant, have not been reported as showing good results from radical extirpation.

It is obviously very difficult to appraise radiation as a post-operative procedure, especially with the possibility of recurrences developing as late as 25 and 30 years.

This study embraces an analysis of the results of 54 cases of parotid tumors.

Thirty-five cases were malignant. Of these, 19 were verified microscopically as carcinoma and 3 as sarcoma; 5 were diagnosed as malignant clinically and 1 of these as sarcoma; 4 were histologically benign and 4 were clinically benign.

Of these 35 cases, 31 died; 3 are not traceable and 1 is living after 3 years. Every death was clinically the result of a typical progressive malignant infiltration. Three of the cases not traceable were histologically carcinoma; the 1 case, living after 3 years, was carcinoma, which was confirmed on biopsy.

There are 19 cases clinically benign. Of these, 7 cases are receiving external radiation. Some of these cases have been under active treatment for 2 and 3 years. No clinical evidence of regression has been observed. Whether growth restraint can be effected will require

many years of study and observation because the life cycle of the benign tumors without appreciable change is variable within a range of 5 to 25 years or more.

Of the 35 cases that were unquestionably malignant, 27 received intensive radiation. Fourteen cases were treated with high voltage roentgen rays; 8 received one series; 3, two series; and 3 six series. Only one of this latter group survived 3 years. A series of treatments is approximately 150% Erythema Skin Doses. There were no survivals after 3 years.

Four received combined roentgen ray and radium packs—approximately 2 saturating series. The duration of life was 7, 11, 18 and 27 months.

Two were treated with gold seeds (2 and 4 E. S. D.) plus high-voltage roentgen rays. These cases lived 1 and 3 years respectively.

Six cases were treated with radium totalling 2, 3, 3, 3, 3, and 5 E. S. D. combined in each instance with gold seed implantations of 10 E. S. D. The total combined dosage averaged 12 to 15 E. S. D. Four of these survived less than a year; 2 cases lived 4 years.

Of the 35 malignant cases, 4 received post-operative high-voltage roentgen ray treatment. All of the 4 cases died from malignant recurrences within 1 year.

Palsy was noted in 6 cases that had no operative intervention. No metastasis to the lungs was found in 11 cases subjected to x-ray studies.

The effects of radiation in this advanced group of 35 cases is not a fair evaluation because of the great extent of involvement in most instances as well as the generally poor physical condition so often associated with the late stages of malignant disease.

This experience has been fruitful in so far as it has afforded abundant opportunity to test the response of malignant parotid tumors to various technical procedures of radiation—high-voltage roentgen rays and radium. The factors of dosage, surface radium packs, interstitial gold radon seeds, with total intensities approaching extensive caustic effects have been carefully tabulated so that each variation would hold a possibility of improving the technique and results.

CONCLUSIONS

(1) Clinically benign parotid tumors are amenable to successful surgical extirpation—the question of the necessity of surgical intervention depends on duration and evidence of decidedly new developments.

(2) Recurrences from so-called benign mixed cell tumors have been found to be malignant—characteristic clinical courses of malignancy—terminating fatally.

(3) Repeated recurrences with a benign clinical course have been noted with the microscopic diagnosis of carcinoma in the primary tumor.

(4) The histologic determinations are not always conclusive for benign or malignant characters.

(5) Roentgen rays have not shown any appreciable effects on clinically benign mixed

cell tumors. The natural, long course of these tumors makes it difficult to draw conclusions about possible good effects.

(6) Advanced primary and recurrent inoperable malignant parotid tumors are very resistant to radiation, according to this experience. No clinical cure was obtained out of 27 cases receiving intensive roentgen ray and radium treatment.

(7) The palliative benefits of growth restraint and relief of pain were of sufficient extent to justify the recommendation of roentgen rays or radium or both when the physical condition of the patient permitted.

(8) The use of highly filtered and weak intensities of radiations given at frequent intervals and over periods of 6 to 12 months seems to offer some outlook of obtaining better growth restraint, and in selected instances, possible clinical cures.

ASPHYXIA NEONATORUM

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"The first quarter-hour after birth is the most dangerous period of life. Its mortality is as great as any subsequent month. No single discovery in medical science or improvement in practice could do more to save lives than would measures to avoid the losses that now occur within a few minutes after birth." This is quoted from a recent article by Dr. Y. Henderson. This fact has been well known for a great many years but little has been done to allay this danger until the last decade and especially the last 3 years.

The most important cause of neonatal death is asphyxia neonatorum. Cruickshank, in a study of 800 infants who died within 28 days of birth, shows that 68% died from this cause alone. Another 25% of these deaths were shown by histologic study to be due to pneumonia. Most of these infants undoubtedly were predisposed to their infection by asphyxial conditions for, to quote Dr. J. N. Cruickshank, "It is obvious that a deeply congested and imperfectly expanded lung is much more

liable to the development of pneumonia than one in which circulation and aeration are free."

We should differentiate 2 forms of asphyxia neonatorum, livida and pallida. The former is an aggravated form of the usual mild asphyxia seen in most normal infants at birth. It is a true asphyxia and therefore requires, in its treatment, adequate pulmonary ventilation. Asphyxia pallida neonatorum is a state of fetal shock most often caused by intracranial injury and hemorrhage. It is analogous to surgical shock and demands practically the same treatment. Certainly, rough manipulations can do nothing but impair its prognosis.

In order to understand the asphyctic phenomena of the new-born, we must first study the normal mechanism for the establishment of respiration. Active and rhythmic respiration in the well-developed new-born is not established unless the respiratory apparatus and the respiratory center present anatomic and physiologic integrity. The respiratory center must be normal to properly stimulate the normal

working of the gas exchange in the lungs. Poor oxygenation of the alveolar blood eventually means anoxemia of the nerve cells in the respiratory center and finally their death. The fetus does not breathe in utero because its normal circulation and gas exchange is such as not to stimulate the center. It is evident that respiration is under chemical control by the action of the carbon dioxide in the arterial blood on the respiratory center. Oxygen is important in this relationship not as a stimulant but as a food for the cells so that they may manufacture carbon dioxide. In asphyxia the arterial content of both oxygen and carbon dioxide is lowered as a rule. Some investigators claim that the carbon dioxide figures may show an increase over normal. However, the depressed respiratory center needs more than normal concentration for its stimulation.

The problem in asphyxia neonatorum is to increase the carbon dioxide content of the blood either by supplying sufficiently adequate amounts of carbon dioxide or by maintaining ventilation of the lungs until a natural increase in blood carbon dioxide takes place. Ventilation cannot be maintained until the pharynx and trachea are free from fluid, the presence of which will prevent aeration of the lungs and eventually cause atelectasis and pneumonia.

All earlier methods of resuscitation were based on the theory that spontaneous breathing was initiated by afferent stimuli. Hence, the use of alternate hot and cold baths, vigorous manipulations of the delicate infant, and counter-stimulation and shock by irritating the skin and stretching the anus. All of these methods were harmful and at times fatal. Moreover, if they apparently were successful, we feel in the light of modern knowledge, that the infant breathed despite the treatment. Plauchu in 1912 was the first to suggest a different, milder treatment. He used intratracheal insufflation of air through a rubber catheter at a pressure of 10 to 15 mm. of mercury. The catheter was small enough to allow the return flow of air and fluid between its outer wall and the tracheal mucosa. He reported good results in mild cases of asphyxia.

In 1928, Henderson reported on the use of carbon dioxide-oxygen inhalators in the treat-

ment of asphyxia. After many years of propaganda he succeeded in having many modern hospitals, police and fire departments, and gas and electric companies equipped with these inhalators for emergency treatment of all forms of asphyxia. Our previous consideration of the physiology of respiration definitely demonstrates the value of this form of treatment. The depressed respiratory center in asphyxia as shown, needs more than the usual 5% of carbon dioxide for its stimulation, 7% to 10% being optimum. Higher concentrations are followed by general depression. You will remember that in both adult and infant asphyxia, carbon dioxide and oxygen are low in the blood, so that the use of inhalations of a mixture of these two gases is logical and indicated. The simplest method of administration would be from a tank of already mixed carbon dioxide and oxygen through any type of mask. Unfortunately this simple method is more or less worthless since carbon dioxide being heavier than oxygen, the former remains at the bottom of the tank so that at first the patient gets almost pure oxygen and later as the tank empties, almost all carbon dioxide. More accurate and effective arrangements are afforded by the H-H inhalator, the Forreger apparatus, or the laryngoscope and intratracheal tube of Flag.

We have been using the Forreger Hospital model at the Newark Beth Israel Hospital for the last 2 years. This consists of individual tanks of carbon dioxide and oxygen mounted on a portable stand. The gases are delivered from the tanks through reducing valves into their respective metric measuring bottles, calibrated in 100 cc. and litres per minute. Thus any desired percentage ratio of carbon dioxide to oxygen can be quickly computed, mixed, and delivered through a Y-tube to a common rubber supply tube. To this is connected a small rebreathing bag and face mask. The nose bag of a dental anesthesia machine may be used but it is preferable to obtain a mask large enough to cover the infant's face, and equipped with an inflated rubber edge, allowing for close apposition to the baby's face without undue pressure. An expiratory valve on the feed handle permits closed rebreathing and the bag can be filled for inflation. In using

the inhalator the usual incidental treatment of the baby is very important, viz., clearing the mucus from the nose and throat by suction, keeping the baby warm and handling it gently. If the infant is not breathing regularly it is well to inflate the lungs by moderate pressure on the partially filled bag a few times each minute. The administration of the gas mixture is then continued as long as the respiration remains subnormal in rate or depth. If, after the administration has been stopped, the infant relapses, renewed treatment can be easily applied. In our experience with this apparatus we have varied the ratio and intervals of treatment depending on the response of the infant. Our results with the asphyxias of moderate degree, with those having persistent cyanosis, recurrent, and with the late appearing cases, have been uniformly satisfactory. One exception was with a full-term male infant delivered normally, who breathed spontaneously at birth and thereafter, but who during the first day and for 3 days more had frequent attacks of cyanosis and shallow breathing unrelated to feedings. The mixed gas inhalation was of no avail and at times seemed to aggravate the symptoms. Inhalations of 30% to 40% oxygen alone were much more effective.

Concerning adverse reactions to inhalations of carbon dioxide and oxygen, A. Peiper and O. Camman report from Berlin on a series of observations from graphic recordings of respiratory changes taking place in premature infants inhaling such mixtures. In a number of cases they noted shock reactions at the beginning of the administrations and also permanent reactions. Occasionally, there were interruptions of the respirations. The authors preferred artificial respiration or the administration of a lobelia preparation or epinephrin in treating infants gasping for breath. They were not convinced that the respiratory disturbances in nurslings can be effectively treated with carbon dioxide. On the other hand, another German author, R. Wiener records his experience with carbon dioxide mixtures in 12 cases of asphyxia neonatorum and in 46 cases of later allied conditions. He concludes that in the aforementioned conditions, such gas

mixtures are always applicable and usually accomplish their purposes.

In addition to the value of this mixed gas treatment in early asphyxia, it is effective for later treatment of the immature infant, the atelectatic infant, and all others that are predisposed to the all too common pneumonia of the new-born, in order to prevent respiratory infections. Henderson has more recently recommended that "every child, even the most normal, should have a 10-minute inhalation at least 3 times a day during the first few days of life as a prophylactic measure against atelectasis and pneumonia". The resulting deeper respirations will materially aid and hasten the normal expansion of the new-born lungs, a process which often takes several days to be completed as has been shown by Coryllos.

A second modern, rational method of resuscitation is one using mechanical, prolonged, passive artificial respiration as in the Drinker respirator, the principle of which is described by its introducer as follows: The patient is placed in a metal box or respirator with his head protruding from one end through a snugly fitting rubber collar. When the respirator is closed, the body is in a relatively airtight container, with the head exposed to the room air. By means of an electrically-driven pump and valve arrangement, changes of air pressure are induced within the respirator. Thus moderate degrees of accurately measured negative pressure are made to alternate rhythmically with atmospheric pressure. When negative pressure is applied, air at atmospheric pressure enters the respirator through the nose, mouth, and trachea, it is drawn into the lungs and then the chest expands. When the negative pressure within the respirator returns to normal, the elastic recoil of the chest produces expiration.

In his more recent paper on the use of the Drinker respirator for asphyxia neonatorum, Murphy states that in the deeper asphyxias it is advantageous to alternate positive pressure with the negative instead of depending solely on atmospheric pressure for expiration. Since there can be no harm to the infant by this change, especially if both pressures are kept at the same level, this investigator now uses alternating negative and positive pressures in

all degrees of asphyxia. A simple adjustment on the respirator allows for this change in alternation. Before using the respirator it is very important that the mucus and other fluid in the pharynx be aspirated else they will be drawn into the bronchi and lungs and may cause atelectasis by bronchial obstruction or a consequent pneumonia. A convenient suction valve is connected to the motor carriage of the respirator and may be used with any suction device.

Treatment is begun with the infant's head tilted back at an angle of 15° to 20° and the body preferably in the supine position. The temperature within the box is kept at about 95° F. by using heat from a 25-watt tubular light attached to the under surface of the lid. The respiratory motor is set to alternate about 40 times a minute at pressures of 8 cm. to 10 cm. as shown on a water manometer. Experience has shown that such settings provide ample pulmonary ventilation. Experimentally, using cats paralyzed with curare, less than 8 cm. was found inadequate, while more than 10 cm., except for very short periods, was harmful. The treatment is continued until the infant begins to breathe spontaneously and regularly or until by inspection and auscultation one is sure that the heart has failed, when further efforts at resuscitation are naturally fruitless. Spontaneous breathing is seen first as a single gasp with spasm of the head and neck muscles. The breathing efforts then become more frequent, rhythmical and strong, until the infant is breathing rapidly and steadily. The motor is now stopped as the infant will ignore the motor rate and influence, and will establish its own rhythm. The baby can be left in the respirator until one is reasonably sure that it will not again need mechanically induced respiration. During this period its normal care can be given with ease.

The advantages of the Drinker respirator can be summarized as follows:

It is easily available and can be used indefinitely to provide adequate pulmonary ventilation with some cardiac support until the respiratory center begins to function.

It is a safe mechanism under ordinary sensible management and causes no damage to

the body since pressure is exerted equally over the whole chest.

The infant body can be kept warm and clean while the head remains outside the box in the cooler, more humid room air.

Our experience with this machine at the Newark Beth Israel Hospital during the last 20 months has coincided with the observations of others, that it enables to ultimately survive, many cases of deep asphyxia once considered hopeless.

ANALYSIS OF CASE REPORTS

Thirty-five infants with varying degrees of birth asphyxia were treated in the Drinker infant respirator, a few being, concomitantly or subsequently, given inhalations of carbon dioxide-oxygen mixtures. Six cases were definitely premature by history and physical examination. Of these 4 died and 2 were discharged in good condition. Twenty-nine full-term babies were treated, 8 dying and 21 being discharged as normal. These results were obtained despite the fact that many had poor maternal prenatal conditions and difficult deliveries. The average period of treatment was 22 minutes. Ten of the 12 deaths (Chart 2) were followed by autopsy examinations. Only 2 showed developmental anomalies as the cause of death, while 5 had evidences of hemorrhage sufficient to cause death. These cases cannot properly be charged as failures of treatment. Three cases showed atelectasis, one with hemothorax. The proponents of the respirator admit that it cannot overcome a true atelectasis, as Coryllos has shown that it takes a pressure of 14 cm. of water to inflate the collapsed lungs of a dog.

Three of our cases showed the effects of narcotics administered to the mother shortly before delivery; all of these survived. Murphy feels that narcotics should be administered not later than 4 or 5 hours prior to the time of expected delivery to offset possibly fatal effects on the infant.

Alpha lobelin was injected into the umbilical cords of 3 infants, who were successfully resuscitated. Since the respirator was also used with these cases, we cannot evaluate the effectiveness of the lobelin. F. Lust claims that lobelin activates the respiratory center,

increasing the frequency as well as the volume of respiration. He uses doses of not over 3 mg. given intramuscularly or subcutaneously with demonstrable effect in 3 to 5 minutes, lasting a few minutes. The author advises repeating the dose every 10 to 15 minutes but admits that we cannot change an immature respiratory center into a mature one within a short time by means of pharmaceutic remedies,

but may occasionally tide over a temporary functional weakness.

The question now arises as to when we should use the respirator and when the gas inhalator. The advocates of the respective methods seem to feel that each is self-sufficient. Our experience leads us to conclude that the respirator excels in inaugurating respiratory movements in the non-breathing,

TABLE 1—INFANTS DISCHARGED ALIVE

Summary of birth history and treatment of 23 cases of asphyxia neonatorum, discharged alive after treatment in the Drinker Respirator.

Name	Sex	Delivery	Condition at Birth	Treatment	
(1)	S.	M	Low forceps	Not breathing	Normal respiration rate in 10 minutes
(2)	M.	M	Normal	Asphyxia livida	Responded
(3)	S.	M	Normal	Asphyxia pallida	Alpha lobelin in cord. 3 gasps first 10 minutes. In respirator 30 minutes
(4)	M.	F	Normal, maternal hypertension	Asphyxia livida	Responded
(5)	K.	M	Cesarean Mother eclamptic	Asphyxia pallida Occasional gasp	6 respirations a minute in first 10 minutes. Treated 30 minutes
(6)	S.	F	Cesarean Placenta previa	Asphyxia pallida Gaspings	Normal respiration in 20 minutes. Treated 1 hr.
(7)	M.	M	Normal	Asphyxia livida Almost pulseless	30 minutes in respirator
(8)	S.	F	Induced Placenta previa	Asphyxia pallida	Normal respiration in 15 minutes
(9)	S.	M	Cesarean	Asphyxia livida Pulse fair. Narcotized	Much mucus in pharynx. First breath 8 minutes. Regular in 15 minutes
(10)	R.	F	Breech extraction	Asphyxia livida Weak pulse	First breath 4 minutes. Regular in 10 minutes
(11)	H.	M	Normal	Cord tight on neck Heart sounds faint	First breath 6 minutes. Treated 20 minutes
(12)	P.	M	Normal Prolonged labor	Premature 8 months Asphyxia livida	Alpha lobelin in cord. Responded in 6 minutes
(13)	S.	M	Normal Gwathmey analgesia	Anesthetized. Livid	First breath 5 minutes. Regular in 10 minutes
(14)	H.	F	Cesarean	Asphyxia livida Heart action good	First breath 6 minutes. Treated 13 minutes
(15)	F.	M	Normal	Asphyxia livida	Responded
(16)	A.	M	Normal	Asphyxia livida Cried once	Alpha lobelin, adrenalin, CO2-0. First breath 15 minutes. Treated 2 hours
(17)	C.	M	Normal Gwathmey analgesia	Asphyxia livida Pulseless	First breath 3 minutes. Treated 30 minutes
(18)	L.	F	Low forceps	Asphyxia livida	Regular in 15 minutes
(19)	Z.	M	Internal Version Breech extraction	Asphyxia livida	Treated 25 minutes
(20)	P.	M	Normal	Asphyxia pallida Irregular heart	First breath 5 minutes. Treated 30 minutes
(21)	S.	F	Cesarean	Asphyxia livida. Anesthetized. Rapid weak pulse	First breath 3 minutes. Treated 30 minutes
(22)	G.	F	Normal	8 months premature Asphyxia pallida Heart irregular	First breath 8 minutes. Treated 40 minutes
(23)	F.	M	High forceps Rapid fetal heart	Asphyxia pallida Occasional heart beat	First breath 8 minutes. Treated 20 minutes

deeply asphyxiated cases who are "on the border line of complete stillbirth." As has been shown, the milder asphyxiated infants who gasp spontaneously will breathe at variance with the respiratory motor. In these the inhalator affords the most benefit with the added advantage of preventing many neonatal pneumonias. It is also obvious that the mixed gases are particularly applicable to the late-appearing and recurrent cyanoses.

There are no reports available on the use of carbon dioxide-oxygen inhalations given simultaneously with treatment in the Drinker respirator. The manufacturers of the latter apparatus have foreseen the need for such combination treatment and have supplied a windowed, metal hood which can be attached to the respirator to completely enclose the infant's head. The inhalator is connected by rubber tubing to the inlet duct of this hood. Two of the infants in our series received this treatment, one recovering, the other dying

from intracranial hemorrhage, as proved by autopsy. We feel that this combination treatment is especially indicated in the severe cases whose first spontaneous gasp is markedly delayed and then repeated only infrequently with long periods of apnea intervening. An analysis of the modern accepted views on the physiology and chemistry of respiration favors the logic and rationale of this combined treatment.

SUMMARY AND CONCLUSIONS

(1) Asphyxia neonatorum is a major obstetric and pediatric problem.

(2) The older methods of resuscitation were unscientific, ineffectual, and harmful.

(3) The Drinker respirator is an effective treatment of deep asphyxia.

(4) Inhalation of a mixture of carbon dioxide and oxygen is valuable in treating milder asphyxias, dispelling atelectasis, and preventing early pneumonias.

TABLE 2—DEATHS

Summary of 12 cases of asphyxia neonatorum who were treated in the Drinker Respirator and died.				
Name	Sex	Delivery	Condition at Birth	Treatment. Cause of Death
(1) H.	F	Abiatio placenta Induced by bag	7 months premature Asphyxia livida	Gasped twice in 30 minutes. Unknown
(2) M.	M	Normal	Asphyxia livida. Pulseless. Bleeding from mouth	Responded with regular weak breathing. Expired same day. Autopsy: Atelectasis. Hemothorax
(3) F.	F	Normal	Breathed normally. Stopped few minutes later	Regular breathing 10 minutes. CO ₂ -0 while in respirator. Autopsy: Intracranial hemorrhage
(4) W.	F	High forceps	Cord around neck	Treated 15 minutes. Autopsy: Intracranial hemorrhage
(5) K.	M	Normal	Asphyxia pallida. Cord collapsed	No breath 15 minutes. Autopsy: Intracranial hemorrhage
(6) H.	F	Normal	7 months premature Asphyxia livida	Normal breathing 30 minutes. Died later. Autopsy: Bilateral atelectasis
(7) R.	M	Normal	7 to 8 months premature Gasping. Cyanotic	In 20 minutes, 3 breaths a minute. Expired. Autopsy: Diaphragmatic hernia. Spleen, stomach in chest
(8) S.	M	Normal	Asphyxia livida Weak pulse	Normal breathing 30 minutes. Cyanotic. Died 18 days. Autopsy: Transposition of aorta, etc.
(9) G.	M	Normal Gwathmey analgesia	7½ months premature Pallid	Breathed 5 minutes. Expired 48 hours. Autopsy: Bilateral atelectasis
(10) B.	F	Normal Gwathmey analgesia	Cord tight around body Pallid	No response. Autopsy: Adrenal hemorrhage
(11) B.	F	Normal	Cord around neck Amniotic fluid, meconium in mouth	Breathed in 20 minutes. Regular in 45 minutes. Died in 56 hours. Autopsy: Syphilitic liver
(12) B.	M	Frank breech	Asphyxia pallida Weak irregular heart	Breathed in 10 minutes. Died in 1 hour. Cause unknown

(5) The treatment of 35 infants with birth asphyxia is analyzed and their birth histories recorded.

DISCUSSION

Dr. I. B. Rothstein (Newark): Until 5 years ago, the subject of asphyxia neonatorum was almost dormant. With the introduction of the carbon dioxide and oxygen mixtures, and the Drinker apparatus, there has been renewed interest in the subject with the resultant return of many workers to this field, and the publication of numerous articles in the recent literature. Dr. Heyman's paper gives a complete survey of this work, as well as a very interesting evaluation of the salient facts.

The renewed interest, and the importance of this subject undoubtedly lie in the hope that these therapeutic measures will be instrumental in reducing our infant mortality rate during the first days of life. It is noteworthy that, despite the tremendous decrease of the infant mortality rate of the first year, the rate for the first few days has been actually little changed. Specifically, within the last 2 decades the city of Newark has shown a drop in rate for the first year, from 200 per 1000 births to the remarkably low rate of 42. The rate for the first months has fallen but slightly in comparison, but does show a drop from 35 to 25 in the last 10 years. However, with all this improvement, the rate during the first few days has shown no decrease. In other words, if there is to be any further decrease in the infant mortality rate, it must come with specific life-saving measures during the first few days of life. We would seem to have some reason to be optimistic but these resuscitative measures have not been entirely proven.

As Dr. Heyman has stated, since 1929 Yandel Henderson has persistently, and more or less convincingly, pleaded for the extensive use of mixtures of carbon dioxide and oxygen for stimulating the respiratory center on the theory that an increased carbon dioxide tension of the blood reaching the respiratory center is the operative factor. Now, however, N. J. Eastman questions the rationale of the use of carbon dioxide in an extensive study of the fetal blood. He shows, first, that the carbon dioxide tension of the fetal blood is normally 1.3 higher than maternal venous blood. He finds this fact incompatible with the state of the fetus in utero, and reasons that the increased carbon dioxide tension must therefore depress the sensitivity of the fetal respiratory center. He further observes that the blood chemical change in asphyxia neonatorum is a reduction in the oxygen content of the fetal blood to extremely low levels, the blood of the umbilical vein falling in fatal cases

below one volume per cent; that the carbon dioxide content is only slightly decreased due to displacement of the gas from the base by the large amount of lactic acid present; and that the serum P.H. of asphyxiated infants is reduced to the lower limits compatible with life. He adduces from his evidence that the use of carbon dioxide as a resuscitating agent in asphyxia neonatorum is not **only** superfluous, but may aggravate an already existing acidosis. He concludes, therefore, that the chief therapeutic indication in asphyxia neonatorum is for oxygen.

It would seem, therefore, that the question of whether or not to use a mixture of carbon dioxide and oxygen or plain oxygen in the treatment of asphyxia neonatorum has not been fully settled.

It is well to point out also that only a limited number of cases of asphyxia neonatorum might be resuscitated, due to the fact that a large number of cases develop pneumonia as a result of aspirated amniotic fluid, and this arises more commonly than is supposed. These cases, of course, have very little chance to live, no matter what procedure is attempted. Hunt, in a recent article, gives the results of autopsies of 118 cases of cyanosis in the newborn. He comments that intracranial lesions, although frequently found, were not always regarded of sufficient severity to produce symptoms or death. Atelectasis was found in one-third of the cases, but only in 4 cases was it severe enough to seem important. However, the most common single lesion found in these autopsies was pneumonia, with the appearance of a hyaline membrane lining the alveolar sacs. This process was probably present long before birth, as a result of aspirated amniotic fluid.

There is very little question in my mind that these new measures of resuscitation are of extreme value in the cases of asphyxia that occur, and will save many lives that previously have been lost. Nevertheless, a larger reduction of the infant mortality rate during the first few days would probably occur with the proper obstetric prophylaxis. On this subject, Hugo Ehrenfest shows that in a large series of complete autopsies performed subsequent to breech labors and after versions and extractions, the immediate cause of death was found to be of traumatic origin in from 80% to 90% of the cases. He further states, that in view of the unmistakable relation of traumatization of the child to artificial delivery, the rapid growth of an operative trend in the obstetric practice of this country cannot fail to prove alarming. Prevention of traumatism beyond doubt would reduce infant mortality during and soon after birth and would better the chances of the newborn infant for normal development.

THE 1934 ANNUAL MEETING

Members of the State Society are requested to note the dates for the Annual Meeting, which will be held as usual in Atlantic City—

JUNE 5 - 6 - 7

The Convention Committees are all busy preparing for this meeting. An interesting program on scientific and economic subjects is being prepared. This should be one of the best attended meetings in the history of the Society.

A REQUEST FROM THE SECRETARY OF THE SOCIETY

Dr. J. B. Morrison, Secretary of our State Society, is preparing a list of medical families in New Jersey, where two or more generations or two or more members in one family have been engaged in the practice of medicine. This material will be stored away in the archives of a Medical History Club to which Dr. Morrison belongs, so that any historian in the future, who carries the history of medicine in New Jersey on beyond the point where we will stop in our outcoming History, may

have these data, given by the living descendants, and thus authoritative, at his command. Letters have been written to the known members of such families, asking for this information, whether the linear descent was direct or not, and whether the members practiced in New Jersey or not. They are also requested to add any other medical history of import. Those physicians who are interested, or who have such information, will kindly send the following data to Dr. Morrison, 66 Milford Avenue, Newark, N. J.

Name

Born at Date

Died at Date

Graduated from University or College of
Date

Practiced in for Years

Practice limited to

Medical Honors or Appointments

Civil Honors or Appointments

Served in Civil, Spanish-American or World War
Rank

Any other medical history of import

.....

State Society Committees

THE WELFARE COMMITTEE MEETS IN TRENTON

A meeting of the Welfare Committee was held on December 31, 1933, at the Stacy-Trent Hotel in Trenton.

The meeting was opened by Chairman Quigley at 2.10 p. m. Those present were: Drs. Quigley, Areson, Bloom, Blumberg, Coleman, Green, Haggerty, Herbener, Kraker, Lawton, Lewis, McKiernan, Mitchell, Morrison, Polak, Rogers, Sewall, Tracy, VanNess, Wood; Dr. Wilkes, Secretary of the Committee; and Drs. Ely, Haussling, Fischelis, and McGuire as consultants.

WORKMEN'S COMPENSATION ACT

President Quigley stated the reason he called the meeting at this time was to revise, if necessary, the report of Dr. Kraker's Committee on Workmen's Compensation Act so that it might be presented to Dr. McBride, Chairman of the Legislators' Investigating Committee, during the following week. Chairman Quigley, Dr. Kraker and Dr. VanNess have already had one preliminary meeting at his request with Dr. McBride's Committee in Newark.

The report was then read by Dr. Kraker as chairman of the Sub-committee on Workmen's Compensation. After a discussion which resulted in certain modifications the report was accepted.

HOSPITAL LIEN LAW

Dr. Sewall reported a bill which had been prepared by his committee to provide liens for doctors' services in accident cases. This bill was modeled on the form of the Hospital Lien Law and was prepared by the committee. Dr. Sewall read the bill and explained its aims and provisions. Dr. Sewall stated that in the approach to the problem of providing a lien for doctors' services in accident cases, there were 2 possible lines of procedure: (1) To amend the present Hospital Lien Law; (2) to introduce an entirely separate act. The latter was preferred by the committee as being simpler and more acceptable to the legislators, and not having the difficulties associated with involving the Hospital Lien Law provisions.

LEGISLATIVE SUB-COMMITTEE

Dr. Haggerty reported for the Legislative Sub-Committee the decisions of that committee, which were as follows:

(See report printed on next page.—Ed.)

MEDICAL PRACTICE

Dr. Lewis reported for his committee on Medical Practice. He said that at a meeting held just prior to the Welfare Committee meeting, it was decided that the subject of medical practice was to be studied with emphasis on the uses and abuses of clinics and dispensaries throughout the State. This study is being undertaken as it is very necessary to gather such data as exists in view of the professional work in connection with the Emergency Relief Administration, especially in urban communities. The Emergency Relief Administration plan is a step ahead of certain provisions which would have been made if the facts had been available to the committee. This was impossible, and no further time should be lost in studying some of the medical problems met in connection with dispensaries in New Jersey.

EMERGENCY RELIEF ADMINISTRATION PROJECT

Dr. Quigley reported on the Emergency Relief Administration Project in which the Medical Society is coöperating on a *mutual* basis. He stated that the lack of definite *data* made the development of the work in large cities much more difficult than in the rural and suburban areas. He mentioned that the 2 situations which had given the most concern to the State Medical Relief Advisory Committee were in Trenton and in Newark but that considerable progress had been made and it was believed that these were now in a fair way to be solved. The aid of the State Director had been directly invoked in bringing the local Emergency Relief Administration directors to agree upon policies, principles and procedures.

PUBLIC HEALTH COMMITTEE

The recommendations of the Public Health Committee on Venereal Disease Control, as noted below, were unanimously endorsed by the Welfare Committee prior to the State Board of Health meeting on January 9. The Executive Secretary was instructed to inform Dr. Mahaffey of the opinion of those 2 committees.

Public Health Hour. The motion was made and seconded that physicians in the Medical Society of New Jersey establish a "Public Health Hour" in which persons might be immunized against diphtheria at \$1 per injection. Arrangements should be made with the Health Department for toxoid and a report of each immunization done by the physician should be sent to the Health Department. (It was suggested that the local Board of Health should be able to provide toxoid for diphtheria im-

munization.) This motion was unanimously carried.

Proposed Venereal Disease Control Change. The Executive Secretary reported that Dr. Casselman had prepared material to show the necessity for medical supervision and maintenance of the Venereal Disease Control Bureau in the State Department of Health. This material had been submitted to the Public Health Committee and the 2 following recommendations had been unanimously approved: (1) That Venereal Disease Control should be directed by a medical man especially trained and experienced in Venereal Disease Control work; (2) that it would not be to the advantage of the people of New Jersey if the Venereal Disease Control personnel were reduced.

L. A. WILKES, M.D.,
Secretary to the Committee.

PLAN FOR HANDLING LEGISLATION IN THE YEAR 1934

The Executive Secretary should be present in Trenton at all times when the Legislature is in session. He will be the Bureau of Information as far as the State Medical Society is concerned, and any member of the Legislature should feel free to talk to him concerning health or medical matters. In these talks the Executive Secretary should, if possible, determine such member's attitude on bills in question, but he is to use absolutely no pressure and is to do no lobbying. He will watch the introduction of bills by means of the Legislative News and Index, and secure copies of any and all bills that will be of interest to the medical profession. Copies of all bills pertaining to the medical profession will be sent to all members of the Welfare Committee, and 3 members will be asked to survey each bill in detail and to submit their reports to the Legislative Committee as soon as possible. These reports will be gone over by the Legislative Committee and a report made at each meeting of the Welfare Committee.

As soon as a bill is referred to committee in the Legislature, the chairman and members of the committee will be asked not to report the bill out until the medical side of the question has been presented to them. After the majority of bills have been introduced, a letter will be sent by the Executive Secretary to each member of the Legislature itemizing the bills that we are endorsing with the reasons

why, and also giving a list of the bills that we are opposing and the reasons why.

After each week's session of the Legislature a memorandum will be sent to the members of the Welfare Committee giving the status of each bill at that time, and containing special requests for action in their respective counties. There will be no lobbying in Trenton, but each member of the Welfare Committee will be asked to contact his senator and representatives at home. When requests for information are sent out we ask that replies be returned as soon as possible.

We insist that each County Society have a local Welfare Committee and that one member, at least, of the State Welfare Committee from that county shall be a member of said committee, in order that he may act as a contact between the State and the County Welfare Committees, thus keeping the County Committee informed on legislation and obtaining the members' opinions on such matters.

We suggest that the members of the County Welfare Committee have a meeting at once with their senator and assemblymen and ask that they not introduce any public health bills until such measures have been gone over by the local committee. We are aware of the fact that many a measure is introduced because a senator or an assemblyman has been asked to introduce it, and that the legislator does not realize the full intent of the bill and afterwards regrets its introduction. A survey of such bills by a local committee of medical men for the legislators means that many obvious bills will never be introduced.

We ask, also, that as soon as the public health bills have been surveyed by the State Legislative Committee, this local committee again see their legislators and tell them the stand the medical profession is taking on these bills; as to why we are opposing some and why we favor others. You will find the legislators, as a whole, are open-minded and will take advice from local doctors who are their friends. The medical profession champions public health and what it asks for, is in the interest of the public good. So there should be no difficulty in convincing fair-minded legislators of the reason some bills are good, while others are harmful.

Finally, we ask that each county have a keyman who will be directly responsible to the chairman of the Legislative Committee for action in that county. He may or may not be a member of the State Welfare Committee, but he should be a man who can, and *will*, act promptly, and one who is interested in the best public health possible.

It is understood that the Medical Society will introduce several bills this year. Committees are now working on these bills. If we are to be successful, it will be necessary that each member work hard on his local representatives in the Legislature.

D. LEO HAGGERTY, M.D., F.A.C.S.,
Chairman, Sub-committee on Legislation
of the Welfare Committee.

School Health Department

DIVISION OF PHYSICAL AND HEALTH EDUCATION, STATE DEPARTMENT OF PUBLIC INSTRUCTION

Allen G. Ireland, M.D., Director

THE PUBLIC HEALTH COMMITTEE

By this time every physician in New Jersey is informed concerning the objectives and recommendations of the Public Health Committee of our State Society. From sentiments expressed, it is known that you approve, and, further, that many of you are at work, carrying out the program.

Concerning the public schools, it has been made known in various ways that the State Department of Public Instruction endorses this move by the State Society and wishes to coöperate in bringing the program to complete fulfillment.

Individual school districts may coöperate by adhering to the fundamental objectives of the school health program. The principle underlying that program is sound. The danger lies in defining purpose and scope too broadly, occasionally to the extent of usurping parental prerogative. We should, rather, confine objectives to the following:

(1) The detection and exclusion of suspected or known cases of communicable disease and of contacts with such cases.

(2) The detection of defects, conditions of health, traits, or peculiarities that will interfere with the child's progress at school, or that may have undesirable effects upon the health or education of others.

(3) The notification of the parent when the above conditions are found, together with an interpretation of the significance of such conditions and a recommendation that a physician be consulted.

(4) The maintenance of hygienic and sanitary conditions at school.

(5) The instruction of the child in the principles and practices of healthful living.

Treatment, other than first aid, is not a purpose of the school health program. It should be undertaken by the school, only when the county medical society officially designates and approves school clinics for known indigents. Such endorsement, or its refusal, is to be one of the functions of the proposed public health committee of the county society.

The problem created by the importance of vaccination against smallpox and immunization to

diphtheria will also be considered by the county public health committee. It will be solved in part by an organized effort to have such work done for infants and young children by family physicians. The high incidence of diphtheria in the early years gives great significance to this move.

When the plans are finally perfected, it is hoped that physicians will enlist in a state-wide project to undertake the examination of young children throughout the preschool period. While the public health values are obvious, this is essentially an activity for the family doctor. It will mean that when children enter school they will be free from handicapping defects and conditions. Doubtless the school will be called upon to participate in the educational campaign this project will require.

STATE CONVENTION

We solicit suggestions for the School Physicians' Section of the State Convention program. What would interest you? Do you have something to present?

MENTAL HYGIENE CONFERENCES

School physicians should plan to attend one of the following conferences being held under the joint auspices of the Child Hygiene Bureau, State Department of Health, and the Division of Physical and Health Education, State Department of Public Instruction.

March 23—State House, Trenton.

May 11—Hotel Cumberland, Bridgeton.

The program is as follows:

Problem of Attitude Toward Health and Sickness

Dr. Earl W. Fuller, Director

Northern New Jersey Mental Hygiene Clinics

Problem of Family Situations

Dr. J. Q. Holsopple, Chief Psychologist

New Jersey State Hospital

Problem of Physical Habits

Dr. James S. Plant, Director

Essex County Juvenile Clinic

Problem of Social Habits

Dr. Bruce B. Robinson, Psychiatrist

Department of Child Guidance

Newark Board of Education

County Society Reports

ATLANTIC COUNTY

L. M. Walker, M.D., Reporter

The Annual Meeting of the Atlantic County Medical Society was held December 8, 1933, at Chalfonte Hotel with 55 members present.

The President of the Medical Society of New Jersey, Dr. F. J. Quigley, of Union City, addressed the meeting and stressed the importance of the Public Health program as put forth by the State Society. He urged the members to keep in touch with the plans and to do everything in their power to coöperate and aid in the progress of this work.

Dr. Davidson reported for the Board of Censors

that the application of Samuel Halpern was acceptable and he was elected to membership in the Society.

Dr. Darnall, reporting for the Library Committee, stated that several new books had been added to the Medical Branch Library.

Dr. Carrington, reporting for the Committee on Post-Graduate Education, stated that the committee had considered 2 courses of 6 lectures, each covering either neurology or the newer diagnostic methods of treatment of internal diseases. He requested the members to state which course they would be interested to have. This was left for further discussion. The cost of the 6 lectures will be \$10 per person unless more than 35 men are enrolled.

The report of the Treasurer was accepted. He stated that as the report showed a deficit, it would be necessary to either increase the dues or find some way of reducing the expenses of the Society for the coming year.

It was suggested that postal cards could take the place of the monthly bulletin now being used; that the advertising in the Medical Roster and Bulletin of the Philadelphia County Medical Society, costing \$48 per year, could be eliminated; and that the membership in the Chamber of Commerce could be withdrawn. After discussion a motion was made by Dr. Allman, and seconded by Dr. Davidson, that the dues be increased to \$16 per member for 1934, this giving \$13 for the State assessment and \$3 for our Society. The matter of reducing expenses was left on the table for discussion at the January meeting.

Drs. Joseph Poland and Samuel Salasin were appointed Auditors.

The following officers were elected for 1934: President, David B. Allman; Vice-President, C. Coulter Charlton; Secretary-Treasurer, John S. Irvin; Reporter, Robert A. Kilduffe; Historian, Halvor A. Harley; Member of Board of Censors, C. H. de T. Shivers; Member of the State Nominating Committee, Walt P. Conaway; Delegates to State Society, Clarence L. Andrews and Walter B. Stewart; Alternate Delegates to State Society, Drs. George A. Poland and Samuel Goldstein; Delegates to other County Societies, Drs. V. Earl Johnson and Harold S. Davidson.

Dr. Allman expressed his appreciation for the honor and hoped he would be a successful leader for the coming year.

The membership of Dr. Maurice Chesler was transferred to New Castle, Delaware.

Delegates from other Societies to Atlantic County for the coming year are:

Burlington: Dr. Joseph Stokes and Dr. Howard C. Curtis, of Moorestown.

Gloucester: Drs. C. A. Bowersox and R. L. Moore, of Woodbury, and Dr. H. M. Forder, of Williamstown, and Dr. V. I. Barrows, of Pitman.

Camden: Dr. J. W. Crowley, Dr. W. D. Evans and Dr. I. E. Deibert, all of Camden.

The Scientific program for the evening was:

(1) "The Acute Abdomen" by Dr. George P. Muller, Clinical Professor of Surgery, Graduate

School of Medicine, University of Pennsylvania, Chief Surgeon to Lankenau and Misericordia Hospitals, Philadelphia. Discussed by Dr. James H. Mason.

(2) "Electro-Surgery in Cancer" by Dr. George Austin Wyeth, member of the Academy of Medicine, New York, and Consulting Surgeon to the Grasslands Hospital, White Plains, New York. Discussed by Dr. W. Edgar Darnall.

Dr. Muller presented a very splendid lecture. He limited his remarks to the more important surgical lesions found in the abdomen and discussed their early diagnosis and treatment.

The surgical conditions which he covered were injuries caused by trauma, stab wounds, ulcers and perforations in the stomach and duodenum, acute gall-bladder conditions, pancreatitis, appendicitis and intestinal obstruction. He particularly stressed the importance of a thorough knowledge of anatomy and pathology on the part of the surgeon.

DISCUSSION

Dr. Mason stressed the importance of making a differential diagnosis between intra-abdominal injuries and injuries to the spinal cord in traumatic cases.

Dr. Darnall discussed the differentiation between intra-abdominal conditions and neuralgia of the hypogastric or ilio-inguinal nerves. He also commended Dr. Wyeth on the splendid work he has done in electrosurgery, but spoke of the dangers of its use in unskilled hands.

Dr. Allman spoke of the importance of the leukocyte count in differentiating between surgical and non-surgical conditions such as appendicitis and pneumonia in children.

Dr. Scanlon stressed the importance of the leukocytic index and also spoke of the difficulty in hospitalizing those cases of ruptured appendix where pain had ceased.

Dr. Senseman mentioned a case of appendicitis complicated by amebiasis.

Dr. Kilduffe discussed the diagnostic importance of the white cell count and the leukocytic index.

Dr. Carrington spoke of the differential diagnosis between appendicitis and adnexal disease.

Dr. Davis spoke of the development of similar lesions in identical twins.

Dr. Stalberg questioned Dr. Muller as to the advisability of the general practitioner attempting to reduce an incarcerated hernia.

In closing the discussion of his paper, Dr. Muller questioned the frequency of the intercostal neuralgia over the chronic appendix and said he did not think it safe to let these patients wait until something happened. He said he thought the leukocyte and differential count, the Schilling index, the Arneth count and the sedimentation time were all of definite value.

He mentioned having operated on a patient with a large fibroid who had a perfect convalescence for a week and then developed a diarrhea. On sending specimens to the laboratory it was found that the patient had amebic dysentery, having been in Mexico one year previously. Diabetic coma was also cited as a stimulant to appendicitis.

In referring to Dr. Carrington's mention of adnexal disease, Dr. Muller said he had not included the pelvis in his discussion, but said that a pelvic appendix did not often cause much trouble even if it did rupture because it was so walled off as to be more or less isolated.

He felt that the practitioner was perfectly justified in trying to reduce a hernia but that it should not be tried more than once and if it could not be reduced, should be left alone.

Dr. Wyeth's paper follows:

CANCER AND ELECTROSURGERY

George A. Wyeth, M.D.,
New York City

Despite the fact that excess publicity is given to many advances in medicine, which are announced on insufficient basis or after insufficient experimentation, it is assuredly true that very real progress in cancer knowledge is being made today.

It is to speak on certain points marking this definite progress that I appear before you this evening.

We are accustomed to think of growth as that fundamental property in life which governs normal increase in size or weight. We know that some animals, which live in water, have no fixed limit of growth—they increase in size or weight throughout life. Other animals, as birds and mammals, have a final, fixed adult size. When this has been reached there is no adult growth except what is needed to keep the body in repair. Any growth manifestation beyond this is considered abnormal, whether it be benign or malignant.

Cells in abnormal growth may result from stimulus from within or from without. Or there may be both. The agencies in the body which so effectively limit the rate and amount of normal growth are ineffective against abnormal growths. If normal epithelium and connective tissue be cultivated together, they affect one another in such a way that each maintains its own identity. Should one of the two be removed, the other loses its power of differentiation and grows rapidly. That is, if kidney tissue is cultivated alone it grows as sheets of undifferentiated cells, but if connective tissue be added to the culture the kidney cells again form the characteristic kidney tubules. Or, as Caramel has also shown, cultures of undifferentiated cells derived from a tumor of the breast can, by the addition of connective tissue, be made to redifferentiate into structures resembling the acini of mammary glands. Cramer has shown that when a normal tissue of an animal is inoculated in another animal of the same specie, it is absorbed as the result of a reaction occurring in the connective tissue. But when a malignant tissue is inoculated a different result occurs. Then the connective tissue reaction provides a stroma and makes it possible for the transplanted malignant tissue to take hold and develop a new tumor.

Therefore, we know that malignant cells are not held by the inhibitions which hold the normal cell in check and it seems that although cancer manifests itself as a local lesion, usually as the result

of some oft-repeated irritation, it would probably *not* so occur except for some underlying constitutional disturbance—some lack of balance in endocrine or metabolic process.

The great work of Virchow in 1850-1860 upon cellular pathology and upon malignant new growths, emphasized the importance of *chronic irritation* as a contributing cause of cancer. It is interesting to note, that the perfection of staining methods for microscopic tissue examination, only in 1872, served to make even more remarkable the accuracy of the great German's description.

We do well to discuss tonight the relative importance of disturbance from within as compared with the disturbance of local irritation as a cause of cancer, because our decision on this point will determine the treatment to be instituted in the individual case.

If we believe that the local lesion is the whole of it, then eradication by surgery will be expected to end the matter, provided the case is seen before the malignant condition becomes generalized. If, on the other hand, we see in the lesion a local manifestation of a constitutional disturbance, then we shall know that the scalpel alone may be an ineffective remedy.

Although most physicians have held the former view, an ever-increasing number are convinced that some biochemical change in the tissues is brought about by conditions affecting the body as a whole. These biochemical changes may be of more than one sort and may have a share in determining the nature of the lesion, the degree of its malignancy, and the susceptibility of the growth to remedial treatment.

We have long known that there are many kinds of cancerous growths. This fact has been the basis for the statement that there can be no one single treatment, no one cure, for all the group of diseases listed under the name of cancer. As ever further our research is pushed, however, we learn that each type of malignant growth breeds true to its own law (is not a lawless riot of cells as was once taught). We learn the nature of substances which definitely stop growth. We learn that by injection and re-injection of tumor extract into an animal the blood of that animal eventually produces an antiserum which, injected into another with a tumor of the same kind, stops that tumor's growth. Learning these, and more of the laws of growth, it is not too much to hope that the day will come when we shall have definite knowledge of, and perhaps control over, the constitutional maladjustment which predisposes to the local cancer lesion.

Meanwhile, of course, the ideal treatment—the treatment which cures all cases of cancer—has not been realized. What is now possible is more accurate diagnosis of the type of the lesion and more accurate choice and application of treatment. No one, in this day, would seek to radiate a fully differentiated, highly radioresistant, adult squamous carcinoma with radium. And no one should seek to eradicate a radiosensitive lesion with a scalpel, without irradiation. This radiosensitivity, or the lack of it, is now easily determined by the rapid frozen section method which can be carried out

as an office routine in time to be of service to the patient. That is, we can learn from proper study of the tumor itself what method will be most effective in its destruction.

In the opinion of the writer, scalpel surgery has been superseded in the removal of both benign and malignant growths. Electrosurgery is taking the place of the older method, because it adds to the finality of removal, the special advantages of protection against mechanical transplantation. The sterilizing heat of electrosurgery is a factor of great importance in the treatment of cancer. It has a range of 3 modalities, each of which has its distinct indication and no one of them should be confused with another, if the best results are to follow.

The lightest current, the monopolar, causes *desiccation*, a drying of the tissues which makes it applicable to all cases where the lesion is on the surface, or in an accessible cavity, or one which can be made accessible, as bladder, larynx, antrum. Once such a lesion is dehydrated, it is curetted away, producing a minimum of secondary reaction, leaving a soft, pliable surface, and insuring a superior cosmetic result. Such a current is one high in voltage and low in amperage and is indicated in all superficial lesions such as leukoplakia, carbuncle, epulis, moles, warts, especially plantar warts, keratoses, papillomas, angiomas, pigmented nevi, etc., where electrocoagulation is contraindicated. Such lesions do not always produce cancer, yet because they are known to be areas especially susceptible to malignant change through irritation, their destruction and removal is an intelligent prophylactic measure against cancer.

The second current, the bipolar, is a coagulating current and its use is indicated for the destruction and removal of lesions which are more widespread and of deeper penetration. Even when expertly used this current leads to a poorer cosmetic result than does the monopolar current and it should never be used if the lighter desiccating current is indicated. It is widespread in its destruction and should be used only by one who has learned how to apply and control its destructive force.

Electrocoagulation is generally combined with excision of the coagulated, inert mass by the endotherm knife, or the original cutting current. Such excision of the neoplasm as dead tissue, instead of as a mass of viable cells, affords—in my experience—a permanence of result, a finality of treatment shown by no other method. It can be employed without hemorrhage and without shock. By its use many so-called inoperable cases have been satisfactorily operated upon. By its use the possibilities of surgery have been very greatly extended. Lymphatics are not opened and thrombosis can be produced *ad lib*.

The sterilizing heat of electrosurgery obviates infection—that great stumbling block to successful treatment by irradiation. There is no telangiectasis, no undue fibrosis to lock up viable cancer cells. Following destruction by coagulation there is a sloughing-off of the edges which leaves a clean wound. I am unable to say whether this coagulum acts, in the process of sloughing, as a foreign pro-

tein to the system, with a beneficial systemic effect as well as a local one; but it is true that the patient experiences a feeling of well-being following such an operation. I have not observed that this reaction follows so promptly any other form of treatment.

Should the case be one in which a closed wound is desired, as in breast removal, the endotherm knife, *without* preliminary coagulation is indicated. Complaint is sometimes heard that primary union does not follow such an operation. In reply to this, I can say that primary union should be the rule, except in excessively fat individuals. Where large sloughings have occurred either the operator or the machine was at fault. Cheap machines, with no selective switch to regulate the amount of coagulation while cutting, make primary healing less likely, if not impossible, and certainly the careless operator who allows the cut edges of his wound to carbonize before his very eyes cannot expect primary union. As a matter of fact, one of the greatest advantages of this method is, that it is under the control of the trained operator, who induces just as much or just as little destruction as his experience has taught him is proper. This destruction destroys both the connective tissue and the epithelial cells.

The new Coutard method of administering x-rays seeks to kill early-formed malignant cells by daily applications of small doses. Whether it is going to accomplish this with permanence it is too early to say; but surely it has won for itself a place in advanced cancer therapy, which *in combination with electrosurgery*, marks another step forward.

At the conclusion of the discussion, Dr. Wyeth stated that primary union was very largely a matter of technic and that the operator should be familiar not only with the tissue but with the currents also.

BERGEN COUNTY

Charles Littwin, M.D., Reporter

ANNUAL MEETING

The annual meeting of the Bergen County Medical Society was held at Hackensack Hospital January 9, 1934, Dr. Alexander in the chair.

The minutes of the last annual meeting were read by Mr. Whitehead and approved.

Three members were elected to Junior Membership as follows: John F. Baldwin, Bergenfield; Andrew F. Ferrari, East Rutherford; John P. Mohair, Maywood.

Three applications for membership were received as follows: Samuel C. Yachmen, Lyndhurst; Vernon L. Hawes, Ramsey; J. F. Benjamin, Ridgewood.

The secretary mentioned the fact that a communication had been received from Robert P. Flschells, Secretary of the New Jersey State Board of Pharmacy, in which he mentioned and enclosed new legislation. It was the consensus of opinion

that excerpts from this legislation be published in the Bulletin.

Dr. Julius Levy sent a notice concerning a series of conferences for nurses to deal entirely with general topics on Mental Hygiene.

Dr. LeRoy A. Wilkes, New Jersey State Executive Secretary, stated that the State Board of Health in Trenton is engaging 100 nurses on a Civil Works Service Project.

A letter from Dr. George S. Stevenson, Director, Division on Community Clinics, for the National Committee for Mental Hygiene, was read, in which he applied for a transfer of membership to Monmouth County.

A card from Mrs. Sarah B. Dunn was read, requesting the resignation of her son, Dr. Theodore B. Dunn, who is a member of the Essex County Medical Society.

Dr. Michael Sarla gave the treasurer's annual report as follows:

Cash on hand January 10, 1934	\$1162.90
Received during year in assessments, dues and ads	4416.00
Borrowed from savings account	1000.00
	<hr/>
	\$6578.90
Disbursements	5375.13
	<hr/>
Balance	\$1203.77
Savings account	\$1081.88

Dr. S. T. Snedecor then gave a résumé of the outstanding events of the last five years. The publication of the Bulletin, the organization and functioning of the Executive Committee and the activities of the Executive Secretary were mentioned as among the real achievements. He hoped that they would continue.

Dr. Joseph Payne read the report of the Nominating Committee. Dr. F. Hallet moved that the secretary cast a ballot for the officers named. It was passed unanimously. The following officers were elected: President, Dr. Arcangelo Liva; Vice-President, Dr. Spencer Snedecor; Secretary, Dr. George M. Knowles; Treasurer, Dr. John H. Irwin; Reporter, Dr. Charles Littwin; Delegates to the State Medical Society, Drs. J. Payne, Herman Trossbach, Spencer Snedecor; Alternates, Drs. Conde de S. Pallen, H. B. Wilson, Joseph S. Vandyke.

Dr. Samuel Alexander, in turning over the presidency to Dr. A. Liva, thanked the members for the honor in serving them as president, and summed up the achievements of the past year.

Dr. A. Liva then took the chair and spoke at length. The speech is to be printed in the Bulletin.

SCIENTIFIC PROGRAM

Dr. Clay Ray Murray, Attending Surgeon, Presbyterian Hospital, New York City, spoke on "Fractures for the General Practitioner", illustrated with lantern slides.

Dr. Frederic J. Quigley, President, Medical Society of New Jersey, then spoke on the many and important phases on "The Program of the State Society".

A motion was passed, requesting the Secretary to send a letter of thanks to Dr. Clay Ray Murray. Meeting was adjourned for refreshments.

BURLINGTON COUNTY

H. P. Shipps, M.D., Reporter

At the annual meeting the following officers were elected: President, Jacob M. Davis, Burlington; Vice-President, J. Howard Hornberger, Roebing; Secretary and Treasurer, George T. Tracy, Beverly.

The January meeting of the Society was held at the Fairview Sanitarium, at New Lisbon. Dr. Wilkes, Executive Secretary of the State Society, and Dr. Shipley, Editor of the State Journal, were present. Dr. Wilkes gave a very helpful résumé of the recent projects of the Administration that affect the practice of medicine. This brought forth considerable discussion of the working of these projects. One subject the Society feels the American Medical Association should take up is the Federal law that bars school physicians and municipal physicians from receiving remuneration for services rendered through the Emergency Relief Administration.

The Society is in favor of coöperating with the State Society program with the Civil Works Service for immunization against diphtheria and smallpox, and health examination of pre-school children.

Dr. R. E. Imhoff, Chairman of the Section on Practice of Medicine, presented the following program:

"Arterio-sclerotic Heart Disease", by Thomas L. McMillan, Cardiologist to Pennsylvania, Philadelphia General, and Burlington County Hospitals. Dr. McMillan discussed especially the value of the electrocardiograph in coronary artery thrombosis.

"Drug Eruptions", by Henry B. Decker, of the Department of Dermatology of Jefferson, Pennsylvania, and Cooper Hospitals. Dr. Decker illustrated his paper with a lantern slide demonstration.

After the program, a fine turkey dinner was served in the dining room.

CAMDEN COUNTY

Vincent Del Duca, M.D., Reporter

The regular meeting of the Camden County Medical Society was held January 2, 1934, at 9 p. m., in the Camden City Dispensary Building, with Dr. T. B. Lee presiding.

Prior to the regular meeting, the Business Committee transacted routine business. It authorized the expenditure of \$10 each to the Assistant Secretary and to Assistant Treasurer for their faithful services during the year 1933.

The President introduced to the Society Dr. LeRoy A. Wilkes, New Executive Secretary of the State Society, and Dr. A. E. Shipley, newly appointed Editor of The Journal of the State Society. They were cordially received.

Dr. William Anderson, 20 Kings Highway, W., Haddonfield, N. J., was duly elected to membership in the Society.

The Scientific program consisted of a paper on "Certain Aspects of the Anemias" by David Farley, M.D., of Philadelphia (by invitation), and a second paper on "Diagnosis of Undulant Fever" by Grant O. Favorite, M.D.

Dr. Farley's paper dealt particularly with pathologic diagnosis, as found in modern laboratory procedure, of the anemias. The use of intramuscular concentrated liver extract for the treatment of pernicious anemia and the use of various forms of iron for the treatment of secondary anemia were stressed.

Dr. Favorite gave a most excellent paper on the etiology, diagnosis and treatment of undulant fever. He impressed the Society with the prevalence of this disease, even in the eastern section of the United States. Dr. Favorite's paper is so timely that it is abstracted more fully, as follows:

DIAGNOSIS OF UNDULANT FEVER

Grant O. Favorite, M.D., Camden,
Pathologist, West Jersey Homeopathic Hospital

Undulant fever is an infectious disease caused by the *Brucella melitensis* and characterized clinically by febrile attacks which persist for weeks or months. Relapses are common.

The first case of undulant fever in the United States due to the variety *melitensis* was reported by Craig in 1903. The disease has been reported from all sections of the country. More than 100 cases are diagnosed in the United States each month. Eighty-five cases were reported in New Jersey for 1931 and 1932, and 80 cases in Pennsylvania for the same period.

Domestic animals, principally cattle and swine, are the chief source of the infection. The disease is transmitted by the ingestion of dairy products or by actual contact with the animals. From 15 to 20% of cattle and 1.5 to 2% of swine are said to be infected. In Pennsylvania, less than 14% of the herds are free from the infection. It seems logical, therefore, that a large percentage of raw milk should contain the organism. This seems to be the chief source of the infection. Entrance through the skin has also been demonstrated.

The infection is more prevalent in country districts and in small towns using unpasteurized milk. Those who handle animals are quite prone to infection. Goats, sheep, swine, horses and birds have been found infected, but aside from cattle, swine and horses present the greatest dangers. By means of the agglutination test the high incidence of the infection has been demonstrated among the population in general.

Undulant fever should be suspected in all cases of continued fever. In many instances it will explain the cause of a cryptogenic fever. The disease is most commonly confused with typhoid fever, malaria, influenza, tuberculosis, sub-acute endocarditis, and rheumatic fever. Because of the variable clinical course, the diagnosis ultimately rests with the laboratory. Nevertheless, we should keep the disease constantly in mind, just as much as typhoid fever, and other clinically allied diseases.

The blood findings are those of a mild secondary

anemia. A leukopenia of 4000 to 6000 is the rule. The polymorphonuclear cells are reduced, causing a relative lymphocytosis as high as 50%. The non-filament polynuclear count may be 34 to 36%.

The *Brucella abortus* causes a septicemia similar to the typhoid bacillus. Finding the organism in the blood establishes the diagnosis beyond doubt. However, the organism is recovered in a small number of cases only.

When obtaining samples of blood for diagnosis at least 10 to 20 cc. should be collected under sterile precautions. This amount supplies enough blood for cultures and agglutination tests.

As early as 1897 Wright and Semple showed that a diagnosis of undulant fever could be made by the agglutination test. This test has been the most important means of diagnosis. The microscopic test of Huddleson is widely used. The method is simple and reliable. To various amounts of the patient's serum is added a drop of antigen consisting of killed *Brucella abortus*. A positive serum will cause immediate clumping of the organisms. The efficacy of this method has been amply proven. Because of its simplicity we have made it a rule to perform the test on all requests for the Widal test coming to the laboratory.

By the time the patient is sick enough to consult a physician, about the second week of the illness, the agglutination test is positive. The agglutinins are present during the active stage and gradually diminish, persisting for a variable period after recovery. In a small number of proven cases the agglutinins may be absent. In these cases we must rely on the blood culture and intradermal test.

In the vast majority of frank cases of undulant fever, the agglutitive titer is high, usually above 1 to 1000, and offers no difficulty in the diagnosis. In certain individuals without the active symptoms of the disease, the agglutination test may be positive in low dilutions. The presence of these antibodies may be due to a subclinical variety of the disease, in which the patient develops mild symptoms. Infection from the ingestion of contaminated milk may occur without producing symptoms, but sufficient to cause an immunologic response on the part of the body. Because of the resistance of the individual or the low virulence of the organism, the patient does not develop the disease.

Bacterium tularensis, the cause of tularemia, is the only organism showing reciprocal agglutination with *Brucella abortus*. This infection can be excluded by its symptomatology and agglutination tests in higher dilutions.

As early as 1918, Fleischner and Meyer found that a *Brucella abortus* protein when injected into the skin of infected guinea pigs caused a definite local reaction. In testing 100 children they found the test positive in 2. Burnet, in 1922, using a filtrate from killed *Brucella abortus* which he called "melitin", obtained a positive reaction in cases of undulant fever. Other investigators using his technique, have obtained similar results. On the other hand, many have claimed insufficient specificity for test.

Enough evidence has accumulated to show that

the use of a bacterial suspension is superior to the filtrate and is less likely to give a false positive reaction. The reaction with the bacterial suspension has proven specific in known cases of undulant fever, and negative in other diseases. The reaction persists after the agglutinins have disappeared. In those cases where the reaction was positive but the blood showed no agglutinins, there was usually a history of infection or exposure.

The positive reaction varies somewhat with the amount and potency of the antigen. The antigen consists of heat killed bacteria similar to a vaccine. About 0.05 to 0.1 cc. of the antigen is injected intradermally. Our experience has shown that a positive test consists of an area of erythema surmounted by a papule which becomes indurated, firm, nodular and persists for days, weeks and sometimes months. A negative test shows a maximum reaction in about 24 hours, and by the end of 96 to 120 hours there is little left. The positive test, however, at the end of this time is still present, as an indurated nodule surrounded by a small area of erythema, and continues to exist long after the negative reaction has disappeared. Yeckel and Chapman have obtained similar results.

Although the intradermal reaction cannot replace the agglutination test, it is a valuable adjunct in the diagnosis of undulant fever. The test has been found positive when agglutinins were absent. Where the agglutination test and intradermal test are negative, the infection can be safely ruled out.

As to prophylaxis, the pasteurization of milk and the abolition of infected live stock would eliminate the disease. The latter procedure, however, is not practical. Infected material should be carefully handled and disinfected. This includes human as well as animal excreta. Those who come in contact with infected animals should protect and disinfect any cuts or abrasions on their body. Immunization of these individuals with vaccine holds some promise of value. It has also proven of value in immunization of cattle. Serum also has been used with some success in animals.

In the treatment of humans, the results have been disappointing. Many forms of therapy have been tried, but with varying results. Vaccine therapy has been the most useful. The vaccine may be administered in the form of the intradermal reaction thereby the initial dose serving a dual purpose. Subsequent injections may be given subcutaneously. The formation of antibodies after the administration of the vaccine have been demonstrated 3 months after the injection. Our experience and those of others have not confirmed this finding.

Discussion of Dr. Farley's paper was opened by Dr. Thomas K. Lewis, who was followed by Drs. Goldstein, Kain, Davis and Farley.

Dr. Favorite's paper was discussed by Drs. Goldstein, Casselman and Shipley.

Dr. Wilkes gave a short talk on the work being done by the State Society for the furtherance of the profession in this state. He was followed by Dr. A. E. Shipley, who outlined the new policy concerning The Journal.

The meeting then adjourned.

There were 68 doctors and guests present.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

Members of the Cumberland County Medical Society held their January meeting in Garrison Hall, of the Vineland Training School, and were entertained in the dining room of the administration building.

Dr. Ray Simkins, President, was in the chair and with Dr. E. C. Lyon, as Secretary, presided over the meeting. There was an exceptionally large attendance. Delegates from the adjoining county societies were present and invited guests of the doctors included Miss Ida Squarewood, superintendent of Bridgeton Hospital; Mrs. Lorana Elwell, of the Bridgeton Red Cross; Miss Hayes, of the Millville Hospital, and Mrs. Moore, of the Vineland Hospital.

The report of the committee on emergency medical relief stated that the doctors were not getting the benefits of the relief, due to lack of coöperation and understanding on the part of the relief officer.

Dr. Ely, representing Dr. Quigley, President of the State Medical Society, presented several subjects of interest to the doctors. The administration of the State Workmen's Compensation Law was shown to have been abused by certain doctors and lawyers. He suggested a committee of doctors of 20 years' practice and good standing in the county be appointed to review the cases. He explained the need of a Doctor's Lien Law whereby they would be enabled to collect for the care of transient accident cases in the hospitals, as the hospitals are now able to do.

The status of the various cults who desire the rights of using the privileges of the medical profession without passing the necessary identical examinations, was presented. The welfare of the family physician was discussed.

With reference to the State hygiene welfare work in immunizing the children with diphtheria toxin-antitoxin, it was suggested a clinic day be set on which the children could be treated for the sum of \$1, the serum to be furnished by the local boards of health.

Mr. Blankensteen, representing the insurance company carrying the group insurance of the members of the society, set forth the advantages of this form of insurance as being noncancellable, has fraternal features which do not limit the age of the member, and assures that the reciprocal relations of the doctors and the hospitals will enable them to carry the insurance at much lower rates.

INFANT WELFARE

Dr. Julius Levy, of the State Child Hygiene Committee, discussed "The Problem of the Unmarried Mother". He remarked that the doctor had always taken an active interest in the social welfare of the community, adding: "First of all, we should be interested in the welfare of the infant. Society has not made the proper approach to this subject. Institutional care has not proven satisfactory. The mortality of children has been too great. The child should have the care of its own mother, when

possible, in a private boarding home. The larger social viewpoint is to prevent foundlings. Judges of Juvenile Courts are finding the problem difficult to solve." Dr. Levy presented statistical charts showing the morbidity and mortality of both mother and child and compared the difference of percentage between private and hospital treatment; also between the various nations. Reduction in the birth mortality must come from the care of the mother, before and after the birth of the child. Asphyxia during labor accounts for a large number. During the first month the largest number of deaths occur. The reduction in sickness in the infant has been mainly in the summer months, due to the better feeding and hygienic conditions. The tables also showed the percentage of illegitimacy in the various counties of the State.

Dr. Dan S. Renner, of the Skillman Sanatorium for Epileptics, presented an elaborate and exhaustive paper on "The Sterilization of Mental Defectives". There are 18,000 mental defectives in the State, he said. The annual cost of maintaining 10,000 is \$4,400,000. Last year 186 persons were added to the list. One person in a State institution for 43 years cost \$10,449. The danger to the person of such operation under modern surgery is very slight. The benefits would be, that (a) they could be released from the institutions, thus eliminating cost of maintenance and (b) the danger of propagation of similar mental defections. The objections are, (a) the moral right of the person and (b) that there would still have to be institutions for their care. Many states have laws permitting sterilization of their defectives. That of California has been most used. "We must be willing to face the difficulties connected with the solution of this serious and menacing problem," the speaker said.

Dr. Edgar A. Doll, of the State Home for Feeble Minded Women, presented both sides of the subject in discussing the paper. "No radical procedure should be taken until the people are educated to the needs, and benefits to be derived therefrom," seemed to be the conclusion of the gathering.

Bridgeton will be the place of the Annual Meeting in April.

ESSEX COUNTY

Earl Le Roy Wood, M.D., Reporter

MEDICINE AND A HEALTH CONSCIOUS PUBLIC

William H. Ross, M.D., President of the Medical Society of the State of New York in 1931, addressed the Essex County Medical Society on January 11, 1934, at the Academy of Medicine, Newark. Dr. Edward W. Sprague, President, presided.

Dr. Ross, coming from Suffolk County, New York, where a very satisfactory arrangement between the physicians and their community has been in successful operation for some years, was well qualified by practical experience to speak on the subject "Medicine and a Health Conscious Public". Suffolk County depends on its medical profession's cooperation through its County Medical Society to provide for its public health and welfare service. Suffolk County with 160,000 population has a 14%

indigency; there are no clinics. The 96 practicing physicians are authorized to treat the needy sick as private patients according to the following fee schedule: Office consultation, \$1; house visit, \$2; maternity fee, \$25; surgical attention, \$5 to \$50; anesthesia fees, \$5 to \$10; assistants' fees, \$5 to \$10. The per capita cost to the County for its public health service was lower than the average, and more satisfactory to many. Last year \$70,000 for medical service was divided equally between hospitals and physicians. The individual physicians received on an average \$507 which included venereal disease treatments and payment for welfare work. The County Health Department, the second in New York State, was first organized by the physicians, who have controlled it ever since. There are 3 members of the Board of Health which the County Medical Society nominates. All activities are controlled by physicians. Questions in dispute are arbitrated by the Economic Committee.

Dr. Ross said that his county's time-tried plan is still satisfactory during the present period when medical service is undergoing one of the greatest revolutions in its history. He stated that any county society could do the same thing and compensate itself against economic loss. He warned against setting fees too high and too close to the regular private fee schedule; the fees, rather, should be minimum. The organized profession should submit plans for the correction of maladjustments it finds. He expressed the opinion that supplying the needy with food, shelter, clothing and medical care will continue as a function of government and the physicians must be protected against loss.

During the business meeting preceding the address, attention was called to many vital matters. Notice was given of the inauguration of the plan whereby immunization work will be taken from the school and clinic and returned to the physicians in their office. The profession is to undertake the responsibility for immunization and preventive medicine. Dr. George J. Holmes, Supervising Physician of the Newark public school system, emphasized the responsibilities of the physicians. He said that the Board of Education was not anxious to continue the immunization and thought its undertaking by the general profession a step in the right direction; it would meet with his personal endorsement. He explained that the work had first been undertaken by the school system at the request of the Health Department. He felt the school function to be education rather than treatment.

Dr. C. Malcolm Tirrell, representing the recently organized Junior Group of the County Society (members practicing less than 10 years), said that they endorsed immunization by private physicians. This report, together with the announcement of the organization of the group, was enthusiastically received.

Dr. Le Roy A. Wilkes, State Executive Secretary, explained state cooperation in the diphtheria immunization campaign. The preparatory program will include a lecture by Dr. Bela Schick and practical demonstrations by our own members.

Dr. Henry A. Brodtkin read a résumé of the salient points of the Copeland-Tugwell pure food act, after which it was endorsed by resolution. Notice was directed to the New Jersey senators and representatives together with a request for all state agencies to make every effort to secure its passage.

The tellers reported the election of the following new members: *Regular*, Drs. Emmett Dunn Angell, David S. Eisenberg, Hyman Friedman, Nathaniel M. Japhe, William Landesman, Aaron Lowenstein, Joseph Metsky, Frank A. Roberts, Isadore B. Rothstein, Samuel Soschin, Mortimer Weiss; *Associate*, Drs. Joseph A. Bocchini, Gerald I. Cetrulo, Hyman Chimacoff, Ethan T. Colton, Thomas Cahill Davis, Joseph F. Fortunato, William H. Fost, G. B. Griffin, Maximilian F. Hubach, William Barclay Nevius, Ralph E. Rosamilia, K. W. Thum.

Younger Group of the Essex County Medical Society

Sol Parent, M.D., Secretary

On January 10, 1934, the younger physicians of Essex County met at the Academy of Medicine in Newark to organize a forum for the discussion of their practical problems.

By-laws were adopted, designating the organization as "The Younger Group of the Essex County Medical Society" and outlining its purpose as "To cooperate with the Essex County Medical Society in its study of the practical problems of the younger physician".

Members of the Society in practice 10 years or less are eligible for membership. Dr. C. Malcolm Tirrell, of Newark, was elected Chairman of the Group, Dr. J. L. Buckley, of Nutley, Vice-Chairman, and Dr. Sol Parent, of Newark, Secretary. The Chairman was designated as delegate to the Council of the Essex County Medical Society, to present to that body the views and resolutions of the Younger Group. A recent city ordinance requiring all food handlers to pay a fee of \$2 for a license and an examination by the Board of Health officials, was discussed and a resolution of protest adopted. The Group voted to meet regularly at least 4 times a year and adjourned until February first.

Academy of Medicine of Northern New Jersey Eye, Ear, Nose and Throat Section

A. Russell Sherman, M.D., Secretary

DECEMBER MEETING

The regular meeting of the Eye, Ear, Nose and Throat Section of the Academy of Medicine of Northern New Jersey was held December 11, 1933, at the Academy. Fifty members and guests were present.

The speaker of the evening was Dr. Samuel J. Kopetzky, who spoke on "Some Problems Concerned with Petrosal Suppuration", saying in part as follows:

Inflammation of the petrous pyramid is a complication of otitis media and not mastoiditis. It

frequently can be prevented by an early and adequate paracentesis.

Such inflammation is influenced by the character of the bone in the pyramid. It cannot happen in a sclerosed bone because of the nature of the bone itself. It may happen in the diploic type of pyramid, but there the type of reaction to the inflammation is different and will be discussed in a later paper.

Inflammation occurring in the pneumatized bones may be divided into 3 main groups, namely the acute, subacute and chronic types.

The acute type presents typical and distinct symptoms which appear when the periosteum of the pyramid is involved. The rapidity of the onset of these symptoms depends upon the rapidity with which the blood vessels are compressed, with resulting coalescence of bone.

The most frequent and important of these symptoms is orbital pain. Its presence in an ear case demands an early x-ray of the pyramids. From this key plate, the progress of the disease can be watched in subsequent pictures. Reappearance of a temporarily stopped discharge and a low-grade fever are other important signs. Occasionally, a sixth nerve paralysis may be present.

Failure to recognize the presence of an acute process may lead to a sudden and explosive meningitis. Successful treatment requires that the case be operated upon before the brain symptoms appear.

An involved petrous pyramid may drain itself and the presence of a continuous discharge in a properly done mastoid suggests such an involvement. In this manner, the case may become chronic, showing no other symptoms excepting that of a continuous discharge and definite changes in the x-ray. Lipiodol may be injected to demonstrate the fistulous tract.

Methods of approaching the petrous apex were discussed. The method of Freckner supplies inadequate drainage. The procedure of Ramadier is at fault because the carotid blocks the discharge. The method devised by Almour supplies an easy method of approach and a thoroughly adequate way of drainage.

Dr. Eagleton gave a short résumé of the development of the study and discovery of petrous apex disease. In his opinion, a large number of cases occurs in medullary bone producing an osteomyelitis. They are the result of a blood stream infection and not the result of an infection through a direct sinus tract.

The Eagleton method of approach to the petrous pyramid has several advantages inasmuch as it permits the operator to see the actual disease. Furthermore, it gives a wide opening for satisfactory drainage.

Dr. Barkhorn said that the Eagleton operation had a real advantage that has not as yet been thoroughly recognized. It is not necessary to touch the middle ear to reach the diseased pyramid. Hence the hearing is not disturbed, as must result from other methods. The operation is very simple and the dura need not be opened. Those

cases which cannot be reached by this method can easily be converted into the Kopetzky type of operation without increasing the danger of the procedure.

JANUARY MEETING

A meeting of the Eye, Ear, Nose and Throat Section of the Academy of Medicine of Northern New Jersey was held Monday evening, January 8, the chairman, Dr. Morgan, presiding.

Dr. William J. Greenfield described 2 patients who had acute poliomyelitis with involvement of the nucleus of the ninth cranial nerve. They were both boys of 10 years, and in each of them the nerve on the right side was involved. There was a paralysis of the right pharyngeal wall and of the soft palate. There was no paralysis of the tongue or of sensation. Lumbar puncture was positive in both cases, and 1 patient died. The second recovered from the disease in 3 weeks, but had a residual paralysis. Dr. Greenfield illustrated his remarks with lantern slides showing the location of the nerve in the brain stem and its distribution in the pharynx.

Dr. Ross E. Faulkner, surgeon-director of the Manhattan Eye, Ear and Throat Hospital, then read a paper on "Anomalies of the Nasal Accessory Sinuses and Associated Pathology", discussing the subject from the standpoint of his own extensive experience in sinus surgery, rather than from the standpoint of the anatomy text-book.

Dr. J. A. Miller pointed out the impossibility of understanding the anomalies of the sinuses without a knowledge of their embryology.

In reply to a question of Dr. Wood's concerning the vidian nerve syndrome, which he had mentioned in his paper, and the sphenopalatine syndrome, Dr. Faulkner stated that he was not convinced that he had ever examined a patient who showed the sphenopalatine syndrome.

The meeting adjourned at 10:15 p. m. Forty members and guests were present.

Surgical Section

At the meeting of the Surgical Section of the Academy of Medicine of Northern New Jersey, the following brief paper was read by Dr. Blackburne:

A SUCCESSFUL OPERATION FOR UNDESCENDED TESTICLE

George Blackburne, M.D., Newark, N. J.

I wish to submit a simple procedure for use in an operation for undescended testicle.

The incision is made diagonally upwards and outwards from the external ring as in an operation for inguinal hernia. Incise the aponeurosis of the external oblique muscle exposing the inguinal canal. Open up the peritoneal pouch containing the testicle and separate the peritoneum from the cord. If possible, retain the peritoneal covering around the testicle by a suture, after its separation. Pull on the cord and cut all bands of tissue holding it

up. If it cannot be lengthened sufficiently for the testicle to reach the scrotum, most of the vessels of the vas must be ligated and cut. The testicle then receives its nourishment from the artery of the vas, and experience has shown that it will develop normally with only this small blood supply.

Next, bore a hole in the scrotum with the finger, forming a pocket. A silkworm gut suture is inserted through the skin at the bottom of the scrotum, up through the lowest part of the testicle and then out through the scrotum again. This is tied, thereby drawing the testicle into the pocket made in the scrotum. The ends of this suture are left long and are fastened to a $\frac{1}{8}$ inch double elastic band which is attached to the inner side of the thigh by adhesive tape. This elastic band is left in place for 1 week, and exerts a gentle but continuous traction upon the cord, thus preventing an invagination of the scrotum, or a slipping-up of the testicle into the inguinal canal. A loose purse-string suture is placed around the cord at the upper end of the scrotal pocket. The operation is completed by suturing the conjoined tendon to Poupert's ligament over the cord, suture of the aponeurosis of the external oblique muscle, and lastly the skin.

The only originality claimed in this procedure is the suturing of the testicle to the bottom of the scrotum, and the application of the elastic traction to this suture. I have used the operation successfully for a number of years and have demonstrated and described it to several other men who have used it with considerable satisfaction.

Section of Medicine and Pediatrics

Benjamin Saslow, M.D., Secretary

The 169th meeting of the Section of Medicine and Pediatrics was held at the Academy of Medicine on January 9.

Dr. J. Polevski, chairman of the section, introduced the speaker, Dr. D. W. Atchley, Professor of Medicine at Columbia University. His subject was:

MODERN CONCEPTIONS AS TO THE CLINICAL IMPORTANCE OF SODIUM CHLORIDE

Dr. Atchley began his talk with a consideration of the relative importance of the Na and Cl ions in the metabolic economy of the body. There are a greater number of Na ions than Cl ions in the body, since much of the sodium is also linked chemically with carbonates, phosphates and sulphates. Just as the K ion is most important in the chemistry of the cell, so is the Na ion most important in blood and cellular tissue space chemistry.

In 1920, Bloom and his co-workers, proved that with a certain few exceptions, all edema resulted from a linking of water with an excess of NaCl, particularly with the Na ion.

Dr. Atchley pointed out that dehydration and salt depletion go hand in hand, and if enough salt is lost, a distinct clinical entity that may well be termed "medical shock", obtains. The symptoms of this condition are similar to those in surgical

shock, and results from a dissipation of salt and water from the vascular tree.

Dr. Atchley next discussed in seriatim, the important diseases which give such a picture of shock. (a) In cholera, death occurs from a rapid salt and water depletion rather than a specific toxin. (b) In simple diarrheas, especially in children, the rapid loss of water and especially of the Na ion, results not only in shock, but also an acidosis because of the breaking down of the natural alkaline buffer substances. (c) In upper intestinal obstruction, as in pyloric obstruction, there is a loss of not only of NaCl and water, but also HCl, and there results an alkalosis in addition to the shock. (d) In lower intestinal obstruction, there also results salt and water depletion, as these substances are lost in a distended non-absorbing bowel. (e) In the various surgical "ostomies", there is a loss of this vital water and salt. (f) In extensive burns, this condition of shock results, because of a rapid loss of fluid from the surface of the burn. (g) In marked perspiration, especially when water without salt is replaced, this condition also results.

Diabetic acidosis deserves special consideration. Due to a perversion of the carbohydrate metabolism, there results, before acidosis develops, a tremendous loss of water and salt through the kidneys. Within the next 48 hours, when ketosis results, sodium is excreted as the sodium salt of the ketone bodies, and a state of medical shock and collapse supervenes. Such a patient surely will die unless he is promptly treated for shock. Dr. Atchley feels that heroic intravenous saline therapy is more important than insulin in such cases.

Dr. Atchley has done much original work in Addison's disease. It has been experimentally proved that one of the functions of the adrenal cortex is to prevent the loss of sodium through the kidney. In Addison's disease, symptoms of shock result from such loss. A striking but dangerous method of proving whether, or not, a given case is one of Addison's disease, Dr. Atchley pointed out, is to place such a case on a salt-free diet. If this disease is present, a state of severe shock and collapse will rapidly ensue. Dr. Atchley has several cases of Addison's disease under his care that are living quite normal existences upon a daily ration of 8 to 10 gm. of salt daily. No cortin has been used in these cases.

In uremia, the renal insufficiency brings about a depletion of salt and water through the kidneys. Our customary and traditional salt-poor diet in these cases is most detrimental to the patient.

Dr. Atchley's consideration of the treatment of the "medical shock", brought about by the conditions previously mentioned, was most enlightening and practicable. Normal saline is far superior to glucose in any strength, in this condition of shock. The saline, to be most effective, should be intravenously given, rather than by hyperdermoclysis. The amount to be given cannot be foretold. The reliable indices of the quantity required are (a) the rise in blood pressure and (b) the urinary output.

Dr. Atchley next considered the therapeutic indi-

cations for the increase or decrease of the salt intake in several diseases.

In hypertension, a restriction of salt certainly does not influence the pressure in any direction. All salt substitutes are worthless, because their efficacy is incorrectly attributed to their advertised dearth of chloride, while the important sodium fraction is really present in the same quantity as in common salt. Certainly, edema can only be increased by their use. Sodium malate, with a euphonious trade name, is at present being extensively used.

In the pneumonias, there is a rapid loss of salt from the body, and the diet certainly should contain its share of well-salted broth or even table salt in capsules.

Dr. Atchley stressed, however, that in acute hemorrhagic nephritis, salt should be restricted, as it may bring about edema or a recurrence of bleeding.

The discussion was opened by Dr. Harry Satchwell. He spoke of the confusion existing in contemporary medical literature concerning the use of sodium chloride in the various types of hypertension. Dr. Max Danzis considered the relationship of salt loss to intestinal obstruction. Dr. Rita Finkler discoursed upon the relationship of the pituitary gland to salt metabolism. Dr. Harold Goldberg considered the fluid intake in the treatment of hypertension.

Dr. Atchley's concise and practical exposition of this controversial subject created a most favorable impression.

The meeting was adjourned by the chairman, Dr. Polevski, at 11 p. m.

The Associated Physicians of Montclair and Vicinity

Edwin A. Seifert, M.D., Secretary

The regular meeting of the Associated Physicians of Montclair and Vicinity was held on December 15, 1933, in the Assembly Room of the Essex County Isolation Hospital at Belleville, N. J.

Mr. Murray A. Jenkins, L.L.D., Counsellor at Law, of New York City, addressed the association on the subject of "Malpractice". A brief discussion of Mr. Jenkins' paper followed and those in attendance enjoyed a collation at the close of the meeting.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

Dr. Davis W. Kramer, assistant professor at the Jefferson Medical College, gave an illustrated lecture on "Diseases of the Arteries and How to Recognize Them" at the monthly meeting of the Gloucester County Medical Society, held January 18 at Hotel Pitman. About 25 members were present. Delegates present from the Cumberland County Society were Dr. Wilson, Dr. Woodruff and Dr. Ramsey.

The Public Health Committee presented an extensive report on vaccination, diphtheria immuni-

zation and periodical health examinations. The report will be discussed at a later meeting of the society.

Following the close of the meeting the members of the society and the Ladies' Auxiliary enjoyed a buffet supper.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular meeting of the Hudson County Medical Society was held at the Carteret Club on Tuesday, January 2. It was called to order by the President, Dr. D. B. Street, at 9:15 p. m.

The Secretary gave a résumé of the Executive Committee meeting which convened at the Carteret Club on December 18, 1933. A communication was received from the County Board of Health, relative to a plan to organize a central committee to be composed of representatives from medical and lay organizations. Each organization wants to have one of its members on this committee, and together they are to formulate plans for the education of the public in regard to the eradication of diphtheria.

It was felt by the Executive Committee that this work should be entirely under the auspices of the County Medical Society which was to assume leadership, and not simply by a part of the group. This is to be taken up with the County Board of Health at a conference in which the public health committee will participate.

The Scientific program was presented by members of the Staff of Bayonne Hospital, with Dr. L. F. Donohoe taking the chair. The papers presented were:

(1) "Lateral Sinus Thrombophlebitis with Complications: Case Report." By Drs. E. Thum and L. Ferenczi, Bayonne.

(2) "Case Presentation: Maggot Treatment of Osteomyelitis." By Dr. M. Frank, Bayonne.

(3) "End Results of Essential Hypertension." Demonstrations of Necropsy Material. Service of Dr. M. Weiss, Bayonne.

(4) "Case Report: Resection of Intestine for Anomaly Causing Obstruction." By Dr. Brooke, Bayonne.

(5) Case Report: Service of Dr. L. F. Donohoe; Intestinal Obstruction Complicating a Congenital Anomaly. (Reverse Rotation of the Colon.) By Dr. J. Madaras, Bayonne.

MIDDLESEX COUNTY

George F. Hilker, M.D., Reporter

The annual meeting of the Middlesex County Medical Society was held at the Woodrow Wilson Hotel, New Brunswick, on December 20, 1933.

The guests were: Dr. Ely, of Somerville; Mr. Louis Compton, Director of the Emergency Relief Administration for Middlesex County; Freeholder Raymond Wicoff, Mr. David T. Wilentz, Dr. J. V. Smith, member of the Board of Institutions.

The speakers were:

Dr. Edel, who spoke on "Chemistry as an Aid in the Detection of Poisons".

Dr. Harrison Martland spoke on "Causes of Sudden Death". His talk was illustrated by lantern slides. Without doubt there never was a more interesting series of talks given to the members of the society.

Dr. Ely spoke on the policies of the Emergency Relief Administration; the gist of which was that the medical problems would be successfully handled only if physicians themselves dictated the policies.

Dr. George Fithian, of Perth Amboy, as Chairman of the Arbitration Committee, gave a summary of what had been accomplished by the Arbitration Committee of Middlesex County.

The retiring President, Dr. W. C. Wilentz, of Perth Amboy, read a paper on the coming problems of physicians. Some of his remarks are published immediately after this report.

The Nominating Committee presented the names of Dr. Joseph Mark, of Woodbridge, as President; Dr. Harry Haywood, of New Brunswick as Vice-President; Dr. Edward Klein as Secretary, and Dr. Frank C. Johnson as Treasurer for the coming year of 1934.

These men were respectively elected.

EXTRACTS FROM THE ADDRESS OF DR. WILLIAM C.

WILENTZ, RETIRING PRESIDENT

MEDICAL RELIEF

Medical Relief has become a major problem during my administration. As you recall, our society, as well as all component parts of the State Medical Society, entered into an agreement with the State Relief Organization to provide medical and surgical care at definite fees to all relief cases in our county. It is quite true that our fees in these cases are insufficient, but we entered this agreement because of our desire to do our share and join in the spirit of the times. So far as I can see, we had no other alternative. I know definitely that the medical man was carrying a load far in excess of his capacity and something had to be done to aid him as well as his fellow-man who found himself in need of medical assistance. There can be no doubt at the present time that both the medical man and his patient are being taken care of to some degree of satisfaction. What is going to happen now that the men on relief are being provided with work and taken off the relief rolls, I cannot foretell; but I cannot see how medical relief work can be discontinued to relief cases unless two or more members of a family are given employment. In this regard, I do not know whether or not we are heading towards State Medicine; but, at least, there is some consolation in knowing that at present, we, medical men are "running our own show" and controlling it fairly satisfactorily. I cannot help saying a word about the effort displayed in our behalf by the committee which I appointed some few months ago—namely, the Medical Relief Advisory Committee of which Dr. Fithian is Chairman, assisted by Drs. Ed. Klein, Mark, Weber, Dicker, Gutman, Rowland, Strandberg and Witmer. When these gentlemen were appointed, they immediately

began to formulate plans for the benefit of our membership. I am proud to state that our organization is leading the way in relief matters. The reason for this progress is due mainly to the frequent meetings that this committee has had with Mr. Compton's most able and sincere assistant, Mr. Geranimo, whose coöperation and assistance has been a revelation to all of us. Our organization is greatly indebted to this committee and I would suggest that my successor reappoint the same members to the Medical Relief Advisory Committee as a means of reward for their most invaluable services to all of us.

ATTENDANCE

Attendance at medical meetings is a problem which presents itself to practically all medical societies; unfortunately, it is also prevalent in our own society. I personally feel that we can and should correct this problem without much delay. Because of this condition, I wish to call your attention to several facts. I am happy to report that the attendance from such cities as Perth Amboy, Carteret and Woodbridge was most gratifying. I cannot say the same about the New Brunswick district. Some of the men may question this statement but I can assure you that it is based upon definite facts. According to The Journal of The Medical Society of New Jersey, there were 49 men in the Brunswick district, while there were 43 men in the Amboy district. On analysis, I found that only 24 of the 49 men in the Brunswick district attended our meetings this year, while 29 out of the 43 men in the Amboy district attended; in other words, Amboy's representation at our meetings was about 70% in contrast to Brunswick's 49%. What can possibly justify the poor attendance of the men from our county seat district? Is it because of possible competition with the Rutgers Club? I do not know; but I understand that the attendance at this club is likewise poor and that the same men who attend their meetings also attend our meetings. Is it because of the many staff meetings at the New Brunswick hospitals? There may be something to this. Is it because our meeting place in Metuchen is out-of-the-way and not centrally located, making it difficult for the men to attend? This is not so, as we all realize. Is it because of the lack of standing of our guest speakers? This certainly cannot be so, since we have had a finer array of speakers this year than ever in the past. Is it because of the contents of the medical papers presented to us? This cannot be so, either, because the range of medicine covered in the various papers could not have been more diversified and interesting. Is it because the men feel that they can learn no more and are not interested? This may be so but I doubt it. Is it because one clique of men are running this society for their own selfish benefit and to the detriment of the others? No man can honestly say that.

Permit me to ask the members who do not attend our meetings the following questions:

(1) What organization is the real backbone of the medical men in the county?

(2) What organization concerns itself with the

troubles and welfare of the rank and file of our medical men?

(3) What organization acts for all of us when the time arises for action and not words?

(4) Why is it that many of our members, who have been highly honored by this society in the past, fail to attend our meetings after their term of office has expired? This society certainly owes them nothing but they definitely are obligated to our organization.

Let me say that, in my opinion, the Middlesex County Medical Society has merited the confidence of its members and should be appreciated by all, young and old, who are interested in organized medicine. Is it possible that there are some members in this organization who cannot realize the transformation that may occur concerning the practice of medicine and how vitally it might affect us all? Is it possible that there are still members of this society who cannot see the benefits that may result from a solid united front on the part of the medical profession in these troublesome times? The more of yourself you put into your society, the more successful will be your society; the more successful your society, the more successful will be your state society; and the more successful your state society, the more influence does it exert politically in your halls of representation. And that is most vital these days. I sincerely hope that my successor, Dr. Mark, will be given a New Deal in respect to attendance.

I wish at this time to publically thank our most efficient and devoted secretary, Dr. Ed. Klein, for his most energetic and untiring devotion to his position. The work entailed in this office takes considerable time from his private practice. By re-electing Dr. Klein this evening, you men have clearly shown that his efforts have not been in vain.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A special meeting of the Morris County Society was held on January 18 at the Morristown Memorial Hospital. This was the first of intra-society clinical meetings that has been planned for the year. The meeting was well attended and President Frost was privileged to preside over more than 50 members and a few guests.

President Frost gave credit to Dr. Young and Dr. Galasso for their efforts in arranging for the meeting and interesting program. Case records with x-ray and slide pictures of conditions with diagnostic procedures and regime of treatment were presented as follows:

(1) "Epidural Abscess" (the relation of back injuries to symptoms of acute surgical abdomen) by Dr. Frank Pinckney with discussions led by Drs. Larson, Sherman and Frost.

(2) "Brucelliasis" (Matta Fever) by Dr. George Young with discussions led by Dr. Eckhardt.

(3) "Thrombo-Angelitis Obliterans" by Dr. Thomas Thomas with discussions led by Drs. Troedsson, Costello and Galasso.

(4) "Pathological Demonstrations", with picture interpretations by Dr. Galasso, presenting "Carcinoma of Gall-Bladder" by Dr. Pinckney; "Carcinoma of Lung" by Dr. Young; "Carcinoma of Uterus" by Dr. Thomas; and "Umbilical Endometriosis" by Dr. Sherman.

The formal meeting was followed by buffet refreshments.

OCEAN COUNTY

Eugene G. Herbener, M.D., Reporter

At the meeting of the Ocean County Medical Society on December 7, 1933, Dr. W. G. Hayden, Secretary of the Society, read a paper entitled "A New Deal in Medicine", which was thoroughly enjoyed by all. A lengthy discussion followed, and all present gained some valuable points which should be helpful in conducting the business affairs relating to our practices.

Extracts from this paper are presented as follows:

THE NEW DEAL IN MEDICINE

W. G. Hayden, M.D., Toms River

I want to say a few words to you tonight about the business side of our practices.

It has often been said that doctors are poor business men. Like it or not, we are.

There are two chief reasons for this, namely, the lack of any business training in our medical schools and the lack of initiative on our part to find out how to operate an office that will be financially successful. Our pride will ruin us if we are not careful. * * *

* * * The average income (gross) of all the physicians of New Jersey is \$5000 a year. There are 4000 doctors in the state, which gives us an annual income of \$20,000,000; in other words, an annual charge of only \$5 for each and every person in the state.

The overhead, or cost of doing business, is 33 $\frac{1}{3}$ % or \$1666 a year, which, deducted from \$5000, gives an annual net income of only \$3333. Out of this amount we must pay for our domestic requirements, take post-graduate courses, go to Europe, and educate our children. Don't forget that our manner of living, by common consent and popular demand, must be above the average. No, we're not doing so well in our chosen profession!

* * * We expensively-produced doctors develop or acquire, haphazard or "hit and miss" or unbusiness-like methods of doing business. At the end of 5 or 10 years we have a lot of money on the books but very little in the bank to show for our efforts, to pay our bills on the "tenth" or to properly care for our families.

Pencil and paper show us that something is wrong, but instead of engaging an accountant or someone in our bank to show us our mistakes, we resort either to overcharging or to undercharging our patients; we literally "hit this or that fellow" saying, "Well, he can stand an extra charge." In resorting to this shortsighted policy we have lost

the faith and confidence of many of our patients, because they are not sure we are dealing fairly and squarely with them. Any dissatisfied customer will not coöperate, especially if he thinks he is not getting a square deal.

Another reason the patient avoids payment of our bills is that we charge for an undesired thing in an undesired way and at an unfortunate and unexpected time, in most cases. We, ourselves, are to blame for this because we fail to educate and "sell" the public on the idea of providing for this emergency; sickness is looked upon as a calamity and is topped off with a financial penalty which is to be avoided if possible.

Then, the ability to avoid the responsibility has been made possible by the medical profession in 3 ways:

- (1) By preventing the occurrence of disease.
- (2) By fostering free public health agencies.
- (3) By making charges which only a small percentage of the people can easily bear.

Then, Mr. and Mrs. Public avoid their responsibility in 3 ways also:

- (1) By absolute inability to pay.
- (2) By plain dishonesty (dead beats).
- (3) By being willing to accept free public service when they are well able to pay. * * *

* * * What are we going to do to remedy our problems?

In my humble opinion the solution of our problems is in one, or more, or all, of the following suggestions which I offer for your consideration:

(1) That a committee of the members of The Ocean County Medical Society be appointed by the President to work out a "Fair Price Code" and a "Fair Practice or Competition Code".

The former to include a minimum charge for each medical and surgical service we render our patients, stepping the price up for those who are able to pay more; in other words the sliding scale method of fees. This plan is fair and equitable to both patient and doctor.

The latter under which we physicians should operate our practices, just like other codes of the Blue Eagle. I think we need to be kept in line just as much as businessmen. If we are unable to agree on these codes let us get an accountant; these codes are for persons who are not on emergency relief.

(2) That we take stock of ourselves and, if we are lacking in diagnostic and treatment skill, or lacking in patience and tolerance, or lacking in the consistency of our fees, then we should not hesitate to right any of these defects. After we have "cleaned our own house and put it in order" let's tell the public that we have done so and that we are now going to give a new deal to everyone.

(3) That, after these codes have been adopted by the society, they be published in all county papers, etc., so that the public can see that we, too, are working with the NRA.

(4) That we stop indiscriminate granting of credit. It seems to me that almost everyone can come into our offices or hospitals and get credit. We shall have to stop this unbusiness-like practice.

(5) That we settle the amount of all medical and surgical services *before* we render services. In my opinion this can be done in a dignified and tactful manner without offending our patients. I do it in my own practice because I have found that patients do not know or understand why I do all the various tests which are so necessary to make a diagnosis.

(6) That we settle each discharged case in one of the following 3 ways:

(a) By payment of our fees in cash.

(b) By payment of our fees in part cash and the balance with a signed agreement to pay in certain monthly payments.

(c) By payment of our entire fees with a signed agreement to pay in certain monthly payments.

(7) As a result of our general house cleaning and advertising program it follows:

(a) By using better business methods in our offices we shall regain a large percentage of that \$365,000,000 which the profession loses each year in our country through unbusinesslike and hazardous methods.

(b) By doing better work in diagnosis and treatment of our patients we shall regain a large percentage of the \$125,000,000 which our patients spend with the various quacks and cults.

(c) By intelligent publicity of our "Fair Price Code" and our "Fair Practice or Competition Code", and by a wise educational program of advertising the evils of self medication, we shall regain a large percentage of that \$500,000,000 which many of our patients spend on self-medication.

(8) The Hospital, Doctor, and Nurse Plan.

This is a plan I have worked out to help doctors to collect their money from hospital patients who are unable to pay in full for their stay in the hospital.

Each of the above—the hospital, the doctor and the nurse—is to receive a proportionate share of the money our patients have available for his or her stay in the hospital.

If we members of the medical profession who are interested in hospitals do not assert an interest in and accept a responsibility for their economic management, then we shall be pushed farther and farther down the scale until we assume the position from which we are not far distant, namely "hired men", more or less—under the power and control of trustees and superintendents. * * *

(In Dr. Hayden's paper, this plan was given at great length, but space does not permit its publication.—Ed.)

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

The monthly meeting of the Passaic County Medical Society was held Thursday, January 11, at the Health Center, Paterson, N. J. Dr. Harry S. Willard presided.

The scientific program consisted of a symposium on "Treatment of Pneumonia". An excellent summary of drug therapy was given by Dr. Charles J. Murn. Rational symptomatic drug therapy, avoiding overdosage on the one hand, and antagonistic

therapy on the other, was emphasized. Optochin Base in selected cases had yielded good results. Oxygen early in the disease rather than in the extremus, was a valuable adjunct. Digitalis in selected cases was used, rather than routine administration.

Serum therapy was discussed by Dr. Louis G. Shapiro. Statistical studies seem to indicate that large doses of a high titre serum are of definite value in type I pneumonia. The decrease in mortality of the serum treated cases was most marked in those having a bacteremia. In type II the results are less encouraging. Serum therapy for type III and IV is not available as yet. The dangers of serum reactions were emphasized.

Miss Van Saun, of the Paterson Board of Health, demonstrated the Neufeld method of sputum typing. This test compares favorably with the mouse method when accurately performed, and requires one hour at the most for completion.

The general discussion brought out the usual treatment hobbies including the diathermy treatment.

An interesting discussion on the use of digitalis in pneumonia gave the edge slightly to those favoring its use in selected cases.

SOMERSET COUNTY

J. L. Young, M.D., Reporter

The Somerset County Medical Society held its regular meeting in the Nurses' home of Somerset Hospital at 8:30 p. m. on December 14, 1933. In the absence of Dr. Flynn, the President-Elect, Dr. McConoughy presided.

Those members present were: Drs. Stillwell, Earp, Piggott, Meigh, Ely, Hegeman, Flint, Barbour, Levy, Albrecht, Henry Borow, McConoughy, Halstead, Craig, Lovejoy and Sferra.

The Secretary read the minutes of the last meeting, which were approved as read.

Dr. Ely, Chairman of the E. R. A. Advisory Committee, spoke on the present status of the E. R. A. and the Medical Society. He pointed out the many faults that this agreement has and also the lack of coöperation between the Advisory Committee and the local representation of the E. R. A.

Applications for membership to the Society were received by the Secretary as follows: Dr. J. Bruce Massey, of Somerville; Dr. Louis R. Panigrosso, of Raritan; and Dr. John M. Cook, of Bound Brook. These were read and the Secretary instructed to return them to the Board of Censors for consideration.

A letter from Dr. J. B. Morrison, Secretary of the State Society, was read, wherein he requested information relative to medical families in our county. Several such families were mentioned and this information will be conveyed to Dr. Morrison in due time.

Dr. Thomas S. P. Fitch read an excellent paper on "Epidural and Subdural Hemorrhage".

Light refreshments were served and the meeting adjourned.

Woman's Auxiliary

EXECUTIVE BOARD MEETING AT TRENTON

Mrs. James North, Chairman of Publicity and
Reporter to State Journal

The regular mid-winter open meeting of the Woman's Auxiliary to The Medical Society of New Jersey was held at the Y. W. C. A. in Trenton on Monday, January 8, 1934, at 11 a. m., with the President, Mrs. Harry Varsil Hubbard, in the chair.

The minutes of the previous meeting were read and approved. The treasurer's report was accepted as read.

Plans for a dinner dance, during the Annual Meeting in June at Atlantic City, were discussed.

The Auxiliary voted to contribute \$100 toward the expenses of the delegate sent to the National Auxiliary Meeting in Milwaukee last June. Mrs. A. J. Casselman reported that the county president's pins could be ordered from Mr. Constable at Bailey, Banks and Biddle, Philadelphia. The 10 carat at \$6 and the 14 carat at \$7.25.

The chairmen of standing committees read their reports.

A letter from Mrs. Horace Whitacre, First Vice-President of the Woman's Auxiliary to the American Medical Association, was read, in which she requested the highest possible percentage of attendance at county meetings during November, December, January and February. Each county is asked to send this information to Mrs. William Gray, 739 Sherman Avenue, Plainfield.

About 60 members representing 11 counties of the Auxiliary were present.

Music was enjoyed during luncheon.

Dr. Alfred E. Shipley, Editor of The Journal, gave an interesting talk on the relation of the Auxiliary to the Medical Society.

Mr. Howard W. Armbruster spoke on the Pure Food Law.

Atlantic County

Anna M. Mally, Corresponding Secretary

A regular meeting of the Woman's Auxiliary to the Atlantic County Medical Society was held at the home of Mrs. W. Blair Stewart, 16 North Jackson Avenue, on Friday, January 12. Mrs. Joseph Poland presided.

Mrs. James H. Mason and Mrs. Samuel Salasin, delegates to the January meeting of the New Jersey State Medical Society (Woman's Auxiliary), gave a report of the proceedings of that meeting. They requested the members of Auxiliaries to protest to their senators and representatives against the Copeland-Tugwell Bill soon to be acted upon by Congress. Our delegates explained that this bill will take the teeth out of the existing Pure Food and Drug Act.

Acting on the suggestion, a motion was passed to reduce the dues from \$2.50 to \$1.50 and to drop dues delinquent before 1933.

We also passed a resolution to send letters of protest to our Congressmen about the Copeland-Tugwell Bill.

Mrs. Carl Surran reported that \$10 had been given from our Distress Fund to a deserving person whose identity was not disclosed.

The Atlantic County Medical Society invited us to attend their meeting which took place on that same evening. After the meeting the members were to inspect the kitchens and food departments of Haddon Hall.

Mrs. David Weeks was introduced as a new member by Mrs. W. Blair Stewart.

Gloucester County

Mrs. Henry B. Diverty, Reporter

The Woman's Auxiliary to the Gloucester County Medical Society held a Christmas party at the home of Mrs. David R. Bremer, 112 North Broad Street, Woodbury.

Christmas carols were sung and games bearing on Christmas were played. Everyone brought an inexpensive gift and took some other gift home. Refreshments followed.

On December 21, 1933, at Hotel Pitman, 9 p. m., the regular business meeting was held, the President, Mrs. Downs, in the chair. After adjournment we joined the doctors in the dining room, where a buffet luncheon was served.

Hudson County

Caroline Culver, Reporter

The monthly meeting of the Woman's Auxiliary to the Hudson County Medical Society was held on the afternoon of Wednesday, January 3, the President, Mrs. Frank P. Nicholson presiding.

The minutes of the previous meeting were read and approved. The Treasurer reported, and the Corresponding Secretary also reported.

Members having birthdays in January paid their dollar, this money going towards the entertainment fund.

The President asked again that we remember to bring books for the Y. W. C. A. Library.

A letter was read from our State President, Mrs. Hubbard, thanking us for our hospitality in entertaining her at our Christmas party.

Mention was made of the A. M. A. broadcasting programs on Mondays and Thursdays, and a committee was appointed to listen in and report at the meetings, in order that we may keep in touch with the health programs which are being put before the public.

Mrs. Charles B. Kelley, chairman for the annual card party, made a plea for all members to cooperate and help make the affair a success.

All members wishing to attend the State Executive Board Meeting in Trenton on Monday, January 8, were asked to send their names to Mrs. Nicholson in order that reservations could be made for them. It was hoped that there would be a large delegation from Hudson County.

The meeting was then given over to the speaker of the afternoon, Miss Martha Bonham, National President, Alumnae Association of National Catho-

lic School of Social Service. She is the social welfare worker at The Foundling Hospital in New York City. She spoke of the many problems which come to the social service worker for solution, and especially of two groups—the very young and the very old—whose care is the chief concern of all such organizations these days. She gave many of her personal experiences.

Tea and a social hour followed when Mrs. S. Herbert Culver, as chairman of hostesses, and her corps of assistants served refreshments and all the members had the pleasure of meeting Miss Bonham.

Mercer County

Mrs. James R. Harman, Reporter

The first fall meeting of the Mercer County Auxiliary was held Friday, December 15, 1933, at the Y. W. C. A. in Trenton. The members of the Executive Board convened for a short meeting previous to a very delightful luncheon served to the ladies.

Immediately following, the President, Mrs. William C. Iones, presided at a business meeting, and the plans for the state meeting to be held in Trenton January 8 were discussed. It was decided also that in March the ladies of the Auxiliary would be hostesses to a large public relations meeting and tea. A benefit card party was suggested, and arrangements for it and the tea are to be completed at a later date.

Somerset County

Esther Levy, Secretary

The Woman's Auxiliary to the Somerset County Medical Society held its bi-monthly meeting at the Nurses' Home, Somerset Hospital, Somerville, in December. After transaction of usual business, Mrs. Dan S. Renner, of Skillman Village, gave a talk on the work at the State Village. She presented her subject in a very interesting and instructive way, telling of the method of admission of patients, medical and surgical care, occupational instruction they receive while at the village and the efforts made to relieve symptoms.

Obituaries

DUBELL, John E., M.D., died on December 31, 1933, at his late residence in Columbus. He was graduated in medicine from the University of Pennsylvania in 1893 and had been a member of the Burlington County Medical Society since 1895.

JOHNSON, Frank C., M.D., of New Brunswick, died as the result of an accident on January 1, 1934. He fell from a cliff at Chimney Rock, a popular summer resort near New Brunswick. Apparently, Dr. Johnson, an amateur geologist, was on the cliff studying rock formations at the time.

Dr. Johnson was born on February 6, 1894, in

East Orange, the son of David Emerson and Carrie Mae Chambliss Johnson. He was graduated from Rutgers University, class of 1916. He was a member of the Rutgers chapter of the Delta Upsilon fraternity. In 1920 he received his medical degree from the College of Physicians and Surgeons of Columbia University. He was a member of the Nu Sigma Nu fraternity and an honorary member of the Alpha Omega Alpha fraternity at Columbia.

The deceased served as an intern at Presbyterian Hospital and Bellevue Hospital, both in New York City, previous to coming to New Brunswick to specialize in pediatrics in 1922. He was a member of the staffs of St. Peter's and Middlesex hospitals and recently was elected Treasurer of the Middlesex County Medical Society.

In October, 1922, Dr. Johnson married Miss Frances Smith, daughter of the late Dr. and Mrs. A. L. Smith.

He is survived by his widow and three children.

McLEAN, John J., M.D., 79, of 92 Fairview Avenue, Jersey City, who had lived there 45 years, died January 12, 1934, of complications following an illness of a year and a half. He was born in Nova Scotia but began practice in Jersey City in 1889.

For a time Dr. McLean served as a member of the staff of the old City Hospital. At the time of his death he was on the staff of Christ Hospital. He was a member of the Lodge of the Temple, No. 110, F. and A. M.; Clan McLeod, No. 70, O. S. C.; Palisade Council, Jr. O. U. A. M.; the Order of Foresters; the American Medical Association; Hudson County Medical Society, and the Physicians' and Surgeons' Club of Jersey City.

He is survived by his widow, Mrs. Anabelle E. McLean, nee Ball, 2 daughters, Ethel F. and Marjorie A. McLean, 2 sons, Dr. Herbert E. and Robert R. McLean, and 4 sisters, 2 living in Nova Scotia, 1 in Alberta, Canada, and 1 in Elizabeth.

SHAW, Harry English, M.D., staff surgeon of the Monmouth County Memorial Hospital for the last 25 years and former President of the Monmouth County Medical Society, died of pneumonia January 17, 1934, at his home, 172 Garfield Avenue, Long Branch, after a week's illness. He was 61 years old.

Dr. Shaw was born at Adelphi, N. J., a son of Henry Martin Shaw and Catherine Van Note Shaw. He was graduated in 1895 from Princeton University and received his medical degree from the New York University-Bellevue Hospital Medical College in 1898. After serving a year as intern at Bellevue Hospital, New York, he established a practice in Long Branch in 1899.

He was a member of the American Medical Association, The New Jersey State Medical Association, the Monmouth County Medical Society and the Practitioners' Society of Eastern Monmouth County. He was affiliated with Phi Alpha Sigma Fraternity, Long Branch Lodge of Elks, and Abacus Lodge No. 182, F. & A. M.

Surviving are his wife, the former Nellie Goodenough, and a sister, Miss Mary E. Shaw, of Long Branch.

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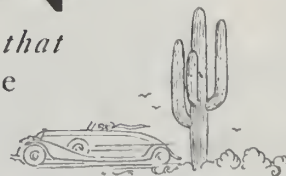
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TEMPERATURE (Mean monthly- 40-year average)	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
	49.7	52.2	57.5	54.3	71.4	77.4	82.7	69.7	79.2	68.1	57.5	49.8
RAINFALL (in inches- 40-year average)	8	9.6	8.1	32	14	23	24	24.6	10	6	7.6	10.9
	Total											115.7
HUMIDITY Monthly (40-year average)	A.M.	61	55.6	44.8	40.4	28.4	29.3	54.3	57.3	47.1	46.8	57.1
	P.M.	35.3	27.7	22.4	22.6	15.9	17.7	36.7	35.7	29.0	26.5	41.1
		Aver										
		49.5										
		29.9										

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OVERCROWDED PUBLIC HOSPITALS

(Sunday Call)

Public hospitals are taxed by the increase in the number of people unable to command private hospital care under existing economic conditions. Private hospitals, on the other hand, have suffered loss of patronage for the same reason. The question whether to enlarge public hospital facilities to meet the increased demand, or to use to a greater degree the space available in the privately conducted institutions for charity patients is one of the problems widely faced. The following comment from a recent issue of The Catholic Charities Review is attracting favorable comment from hospital authorities in New Jersey; it emphasizes both the economy and cooperative phases of the policy of using private hospitals for the overflow of patients from the overtaxed public institutions:

Many cities are now confronted with the question whether they should develop additional public hospital facilities or use the private hospitals. A few years ago the assumption was all in favor of enlarged public hospital facilities. Nobody wanted to measure the cost. It was such a little thing, anyhow. Just an additional indebtedness of half a million or so. Now it is a different story. Economy has become a real argument. The taxpayers are having their inning, and they are determined to purchase service as economically as possible. Only recently Cincinnati and St. Louis, 2 cities that had been committed to the public care of the sick, decided to use private hospitals for their overflow. In both cities it was a question of using the private hospitals or building additions to their overcrowded public hospitals.

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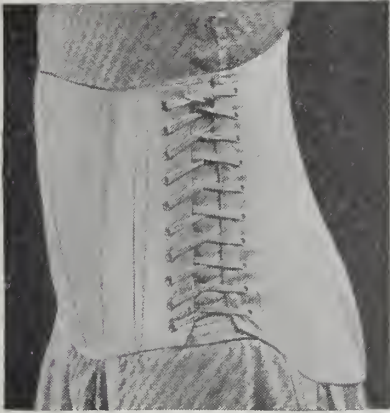
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		CHARLES B. SMITH (1936)	Washington

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Second District (Sussex, Bergen, Hudson and Passaic Counties)	S. T. SNEDECOR, Hackensack (1935)
Third District (Mercer, Middlesex, Somerset and Hunterdon Counties)	F. G. SCAMMELL, Trenton (1934)
Fourth District (Camden, Burlington, Ocean and Monmouth Counties)	JAMES A. FISHER, Asbury Park (1936)
Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties)	ALDRICH C. CROWE, Ocean City (1935)

DELEGATES

Delegates to the American Medical Association

WALT P. CONAWAY	Term expires 1934
JOHN F. HAGERTY	" " 1934
E. R. MULFORD	" " 1935
A. HAINES LIPPINCOTT	" " 1935

Alternate Delegates

PHILIP MARVEL	Term expires 1934
GEORGE H. SEXSMITH	" " 1934
S. B. ENGLISH	" " 1935
STEPHEN T. QUINN	" " 1935

SCIENTIFIC SECTIONS

Chairmen for the Annual Meeting of 1934

Section	Chairman
Eye, Ear, Nose, Throat	S. T. HUBBARD, Hackensack
Pediatrics	WALTER B. STEWART, 8 N. Tallahassee Ave., At. C'y
Radiology	C. B. KAIGHN, 905 Pacific Ave., Atlantic City
School Physicians	A. G. IRELAND, Trenton Trust Bldg., Tr'n

STANDING COMMITTEES

Committee on Scientific Work

LOUIS C. LANGE , <i>Chm.</i> , Weehawken	Term expires 1934
RALPH K. HOLLINSEAD , Westville	" " 1935
CLARENCE C. ANDREWS , Atlantic City	" " 1934

Committee on Publication

HENRY C. BARKHORN , <i>Chm.</i> , Newark	Term expires 1936
EDWARD J. ILL , Newark	" " 1934
LINN EMERSON , Orange	" " 1935
FREDERIC J. QUIGLEY	Ex-officio
J. BENNETT MORRISON	Ex-officio

Committee on Finance and Budget

HARRY R. NORTH , <i>Chm.</i> , Trenton	Term expires 1939
ALFRED STAHL	" " 1934
JAMES S. GREEN	" " 1935
HERSCHEL PETTIT	" " 1936
WILLIAM G. HERRMAN	" " 1937
WILLIAM J. SWEENEY	" " 1938

Committee on Program and Arrangements

WILLIAM J. CARRINGTON , <i>Chm.</i> , Atl. City	Term expires 1935
JOHN W. GRAY , Newark	" " 1934
WILLIAM D. OLMSTEAD , Atlantic City	" " 1936
FREDERIC J. QUIGLEY , Union City	Ex-officio
J. BENNETT MORRISON , Newark	Ex-officio

Committee on Honorary Membership

THOMAS W. HARVEY , <i>Chm.</i>	Term expires 1934
W. E. DARNALL	" " 1935
EPHRAIM R. MULFORD	" " 1936

Committee on Hospitals and Medical Education

HARRY H. SATCHWELL , <i>Chm.</i>	Term expires 1936
WILLIAM W. BROOKE	" " 1935
ARCANGELO LIVA	" " 1934
JOHN H. CARLISLE	STUART Z. HAWKES
CHARLES H. DE T. SHIVERS	CHARLES B. KELLEY
WILLIAM R. LITTLE	EARL H. SNAVELY
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J. VINCENT SMITH	

Committee on Medical Defense

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E. REISSMAN	

Committee on Insurance

FRANK W. PINNEO , <i>Chm.</i>	CHESTER I. ULMER
BARCLAY S. FUHRMANN	A. DUNBAR HUTCHINSON
EDMUND N. HUFF	WAYNE W. HALL
WARREN D. ROBBINS	

Welfare Committee

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SAMUEL ALEXANDER	Park Ridge
WILLIAM H. ARESON	Montclair
LAWRENCE H. BLOOM	Phillipsburg
JACK BLUMBERG	Elizabeth
JOHN C. CLAYTON	Freehold
A. H. COLEMAN	Clinton
JOSEPH G. COLEMAN	Hamburg
EDWIN H. COWARD	Atlantic City
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DAVID W. GREEN	Salem
D. L. HAGGERTY	Trenton
EUGENE G. HERBENER	Lakewood
DAVID A. KRAKER	Newark
ANDERSON A. LAWTON	Somerville
THOMAS B. LEE	Camden
THOMAS K. LEWIS	Camden
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PROSPERITY AND THE BIRTH RATE

(New York Herald-Tribune, Nov. 1, 1933.)

New and somewhat unexpected considerations have been injected into the much-disputed question of high or low birth rates by recent researches of Dr. Liebmann Hersch, the distinguished professor of statistics at the University of Geneva. Traditional nationalistic doctrine has it that high birth rates are desirable to provide young men as soldiers; opponents of the theory say as "cannon fodder". Conventional Malthusian doctrine, on the other hand, insists on the desirability of low birth rates so that the productivity of the soil may not be exhausted or the world's inhabitable region overcrowded by mere excess of human beings. Whatever the theories, there is no question that world birth rates actually are falling. One effect of this, Professor Hersch unexpectedly concludes, is to aggravate and possibly to have caused the present world-wide disturbance of business and depression of industry.

Until about the last quarter of the last century birth rates in Europe averaged in the neighborhood of 40 to 1000 of population. Rates in the United States seem always to have been somewhat lower, but the difference was not great. Nowadays all over the civilized world birth rates have fallen to below 20 to 1000; in at least one country, Sweden, to lower than 15. There has been no notable decline in total population, since the decrease in births has been matched by medical accomplishments in decreasing deaths. Accordingly, the Malthusians are not especially pleased, but neither are the nationalists, as is evidenced by present propaganda in Europe's two most nationalistic countries, Italy and Germany, toward the reversal of the birth rate's downward trend. Professor Hersch is no more pleased than any one else, but his grounds for disquiet are different ones. Decreasing births

have caused, he points out, a sudden change in the age composition of the population. There are fewer children, more adults, many more older adults. Consumers have been decreased in proportion to producers. The result is what he calls "essential" or "structural" unemployment, caused and maintained by this fundamental change in the structure of the population. Whether this viewpoint be accepted or rejected by the experts, it is evident once more that human affairs are seldom so simple as the theorists assume.

HEALTH EXAMINATION SHOULD OPEN SEASON FOR TRACK ATHLETICS

(Hygeia Release, Dec. 18, 1933.)

The track athlete should learn that it is as important to keep a right mental attitude as it is to build up the muscles of the body, for the mental obstacles which athletes find it impossible to overcome are sometimes of a peculiar nature, advises Alfred E. Parker in the January Hygeia. His thirteenth chapter of the serial, "Training for Athletics and Health", deals with "Training for Track".

The track athlete should, as a general rule, develop the muscles of his entire body. For most events, the best practice when stepping onto the track is to stretch the muscles by exercise. Then a slow jog, bringing the legs up high, will limber up the muscles and stir up the blood. Fast sprinting rather than slow running helps the wind. Exercise should start slowly at the beginning of the season and should be followed by a gradual building up of the body to a maximum effort in the latter part of the season. An examination by a physician at the start of every season should be had by every athlete to determine the soundness of the heart.

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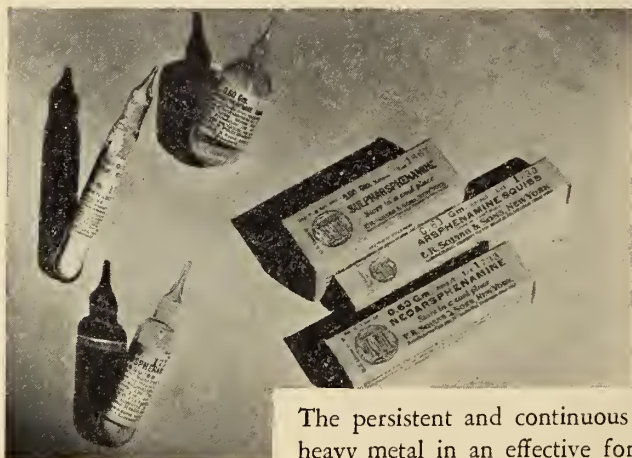
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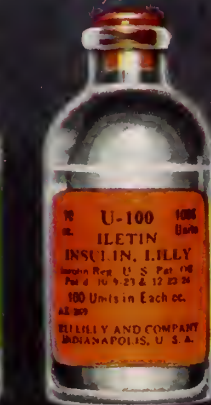
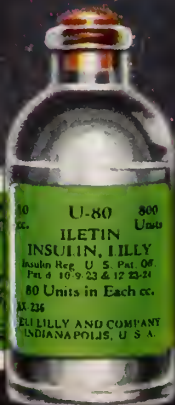
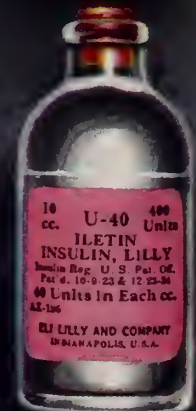
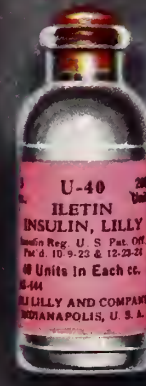
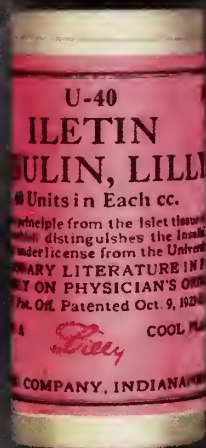
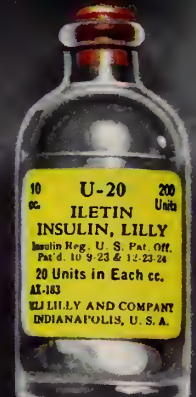
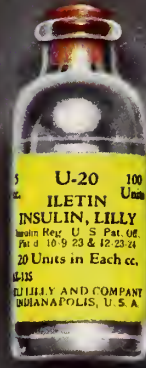
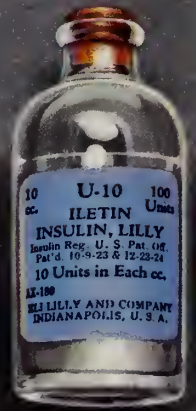
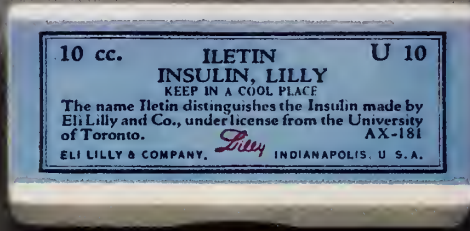
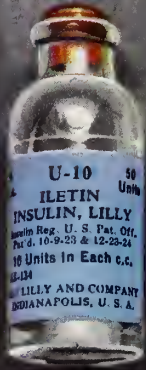
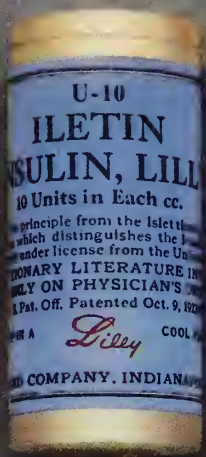
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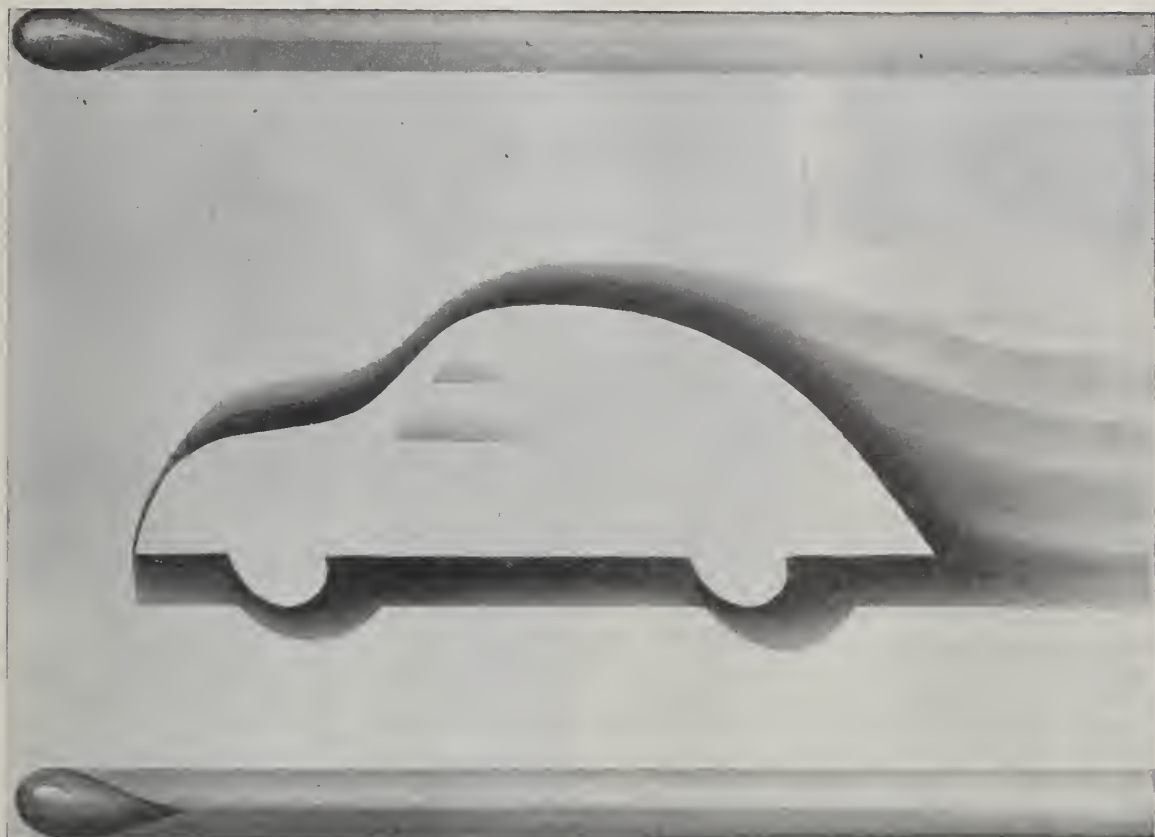
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"As to the kind of extra carbohydrate to be added, whether lactose or maltose, I believe dextrin-maltose to be better in general in cases of fat indigestion (infantile atrophy)."—C. H. Dunn. *The Hygienic and Medical Treatment of Children*, Southworth Co., Troy, New York, 1917, V. 1, p. 418.

In discussing the treatment of decomposition, Feer says: "The period of repair may be shortened by giving suitable additional food; the best, probably, being buttermilk to which carefully regulated proportions of dextrin and maltose preparations or malt soup are added."—E. Feer: *Text-Book of Pediatrics*, J. B. Lippincott Co., Phila., 1922, p. 284.

In the treatment of infantile atrophy, Fischer recommends the following: "The carbohydrate should be increased by gradual addition of dextri-maltose.

"Malt soup or dextrimaltose (Mead's) should be added in teaspoonful or more doses to each feeding until the point of carbohydrate tolerance is reached."—L. Fischer: *Diseases of Infancy and Childhood*, F. A. Davis Co., Phila., 1925, V. 1, p. 285.

Concerning the treatment in the case of a premature infant, Fischer states: "Dried milk with water was given, which later was changed to whole milk, 14 ounces, water, seven ounces, and dextri-maltose No. 1, one and one-half ounces. Seven feedings of three ounces each every three hours was given. The above feeding was retained. The infant gained eight ounces at the end of the first week."—L. Fischer: *Clinical notes in a series of premature infants*, Arch. Pediat. 44:227-231, April, 1927.

Grulee, in discussing the treatment of decomposition, says: "As a rule it is best to start with 2 to 2½ or 3 ounces of albumin milk to the pound weight in 24 hours, the sugar to be added is in the form of a maltose-dextrin mixture. One should never delay too long in adding this."—C. G. Grulee: *Infant Feeding*, W. B. Saunders Co., Phila., 1922, p. 265.

Referring to the hypotrophic infant, Herrman writes: "In mild cases, the addition of dextrimaltose instead of cane or milk sugar may be sufficient to obtain a gain in weight."—C. Herrman: *The treatment of nutritional disorders in artificially-fed infants*, New York M. J. 114:158-160, August, 1921.

In discussing artificial feeding in atrophy, Hess states: "The carbohydrates are usually added in a slowly fermentable form, such as the maltose and dextrin compounds, which are usually started by the addition of four grams per kilogram (1/15 ounce per pound) and increased until eight grams or more per kilogram (¼ ounce per pound) of body weight are added."—J. H. Hess: *Feeding and the Nutritional Disorders in Infancy and Childhood*, F. A. Davis Co., Phila., 1928, p. 278.

Concerning the treatment of marasmus, Hill says: "When the stools have become smooth and saive-like, carbohydrate, in the form of dextrimaltose, may be gradually added up to the limit of tolerance."—L. W. Hill: *Practical Infant Feeding*, W. B. Saunders Co., Phila., 1922, p. 281.

"A spasmophilic baby on bottle feeding should receive a limited amount of milk—a pint, or at the most 24 ounces in the 24 hours—to which cereal gruel and some form of sugar is added, preferably one of the malt dextrin preparations; also the early addition of other foods than milk to the baby's diet."—M. Jampalis: *Infantile spasmophilia*, Interstate M. J. 25:652, Sept., 1918; abst. Arch. Pediat. 35:691, Nov. 1918.

With reference to the treatment of diarrhea, Lust writes: "After several days, 2% to 3% of a maltose-dextrin preparation may be added (Dextri-Maltose). This is preferable to the easily fermentable lactose or cane sugar."—F. Lust: *The Treatment of Children's Diseases*, J. P. Lippincott Co., Phila., 1930, p. 145.

"The treatment of artificially fed children in the first of these groups consists in putting them on a low fat dietary, and giving them carbohydrate in the form of one of the less fermentable sugars—e.g., dextrimaltose."—L. G. Parsons: *Wasting disorders of early infancy*, Lancet, 1:687-694, April 5, 1924.

Pearson and Wyllie in discussing the treatment of milder cases of inanition say: "Regulation of this disturbed organismal balance is obtained by the addition of carbohydrates, while fat and casein are reduced. For this purpose dextrimaltose and flour are better than the ordinary sugars, since they are more slowly absorbed and have greater efficacy in their powers of controlling the flora in the large intestine."—W. J. Pearson, and W. G. Wyllie: *Recent Advances in Diseases of Children*, P. Blakiston's Son & Co., Phila., 1930, p. 116.

Regarding the treatment of the marantic infant, Raue states: "After the intolerance to sugar has been overcome a carbohydrate, preferably Dextri-maltose, may be added."—C. S. Raue: *Diseases of Children*, Boericke & Tafel, Phila., 1922, p. 427.

In discussing the treatment of atrophy, Thursfield and Paterson, state: "If the baby continues to improve, the next step in the treatment is to add to the milk one of the less fermentable carbohydrates, such as dextrimaltose . . ."—H. Thursfield and D. Paterson: *Diseases of Children*, William Wood & Co., 1929, p. 105.

"I also find dextrin-maltose an excellent addition to albumin-milk when the first object of that food has been achieved and a gain in weight is desired. In this way I have succeeded in feeding albumin-milk far beyond the period usually advised, with highly gratifying results."—F. L. Wachenheim: *Infant-Feeding; Its Principles and Practice*, Lea & Febiger, Phila., 1915, p. 158.

"Dextri-maltose has been substituted for lactose not infrequently, when the tolerance for the latter continues low."—I. H. West: *Low fat, high starch evaporated milk feeding for the marasmic baby*, Arch. Pediat. 48:189-193, March, 1931.

"Malt sugar is indicated when others fail to produce a sufficient gain, or when malassimilation of fat is evident."—O. H. Wilson: *The role of carbohydrates in infant feeding*, Southern M. J. 11:177, March, 1918; abst. Arch. Pediat. 35:447, July, 1918.

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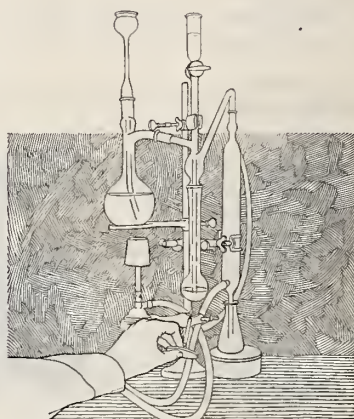
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The services of transportation and power, starting as private enterprises, are rapidly coming under government control, after passing through an intermediate stage in which fierce competition usurped the place of coöperation. The same trend toward governmental control is evident in merchandising and other forms of commerce, and will continue unless business men and financiers develop a sincere spirit of coöperation among themselves.

The service of education is a private as well as a governmental function, with voluntary coöperation an essential element of both methods. There was a time when education was denied to most persons on the ground that, if they were enlightened, the people would revolt against governmental control. But education has developed so far that governments recognize the rights of the individual in education and rely on the school, the newspaper, the lecture platform, the moving picture and the radio for securing the intelligent support of independent individuals. Education is a coöperative function which is available to all who can profit by it.

Medicine has hitherto been practiced by the individual method; but in recent years a strong movement to make it a governmental function has sprung up, fostered largely by "Foundations" with millions of endowments. The reason for the suggested change is the fact that a considerable proportion of the people has not received adequate medical service. Physicians are keenly aware of this defect in the distribution of their services, and have frequently suggested the remedy of coöperation with the government. Physicians agree with the National Committee on the Costs of Medical Care, which reported that economics is a major factor in the unequal distribution of medical services. Physicians have also insisted that provision for distributing medical services to the needy rests upon society as well as the practitioners of medicine—the doctor to render the services to the poor on a personal basis; and the community to pay the doctor's fees when the patients are unable to do so. Physicians desire to place the service of medicine on the basis of their voluntary coöperation with the community so that every person may receive adequate medical treatment.

Physicians have it in their own power to control the evolution of the practice of medicine, and to direct its trends into the field of voluntary coöperation, thus avoiding governmental control and state medicine. This power lies primarily with the county medical societies. Each county has medical problems which are peculiar to it alone. The major problems of Essex County are not those of Cape May, and the methods adapted to the one county

will not apply to the other. But the great principle of voluntary coöperation will apply to all physicians in every county.

Each county society is a unit of medical administration, just as each physician is a unit in the practice of medicine. The leaders of each society know the needs of their own county. They are also acquainted with the officials of the local government and the lay health organizations, and can influence those officials to coöperate in providing efficient medical services according to the present methods of individual practice of medicine. To develop agreements with the officials will require effort on the part of the medical leaders, and months of time; but the plan has been already demonstrated successfully in several counties in New Jersey, and will undoubtedly be adopted by all.

The county societies cannot leave the execution of the details of the coöperative work to the State Society. The parent organization will formulate the principles on which the work will be done, but the actual execution of the plans must be done by the county society.

Two major objectives which the Medical Society of New Jersey have set before the county societies are diphtheria immunization, and the care of the indigent, both of which are fields in which state medicine flourishes. The physicians of each county can readily develop a practical solution of each problem on a coöperative basis, with the advice and assistance of the officers and committeemen of the State Society if necessary.

The success of the plan of voluntary coöperation depends on the ability and devotion to duty shown by the practicing physicians—qualities which they possess in the highest degree.

Doctors' Strike in Cuba

The metropolitan newspapers have recently reported that the City of Havana is having a doctors' strike. This item may have a bearing on the practice of medicine in New Jersey. Cuba, like New Jersey, has a population of about 3,500,000, of whom about half a million live in a metropolitan area. Each has about 3000 practicing physicians, or one to every 1200 of population. But the conditions of

medical practice in Cuba are very different from those in New Jersey, and are such that a strike would be possible among the doctors of Havana. These conditions are described by Dr. R. G. Leland, Director of the Bureau of Economics of the American Medical Association, in the Association's Bulletin of June, 1933.

The method of medical practice in Cuba is predominantly that of sickness insurance. The system originated between 1870 and 1880 on the great plantations whose owners established medical service as an industrial measure in order to maintain their workmen at a profitable standard of working ability. While at first the service was at the expense of the plantation owners, a system of medical insurance was soon developed in which all forms of medical service, including hospitalization, were provided at a cost of two dollars per month, per person. The plan was put into operation throughout the island by a system of super-salesmanship so effectively that nearly everybody joined the insurance societies and only a comparatively few persons were left to pay fees to the independent physicians who practiced medicine on an individual or family basis. The dues in the societies were sufficient to support not only the medical service, but the theaters also. The salaries paid to the doctors employed by the insurance companies were far below a living wage; yet the physicians could not engage in private practice, because practically everybody in the more prosperous classes was insured. Every effort was made to please the people and to keep the system popular. If, for example, a member dropped out from inability to pay his dues, nevertheless, if he was taken sick, he was given free medical treatment. The reason for the apparent altruism of the service lay in the abuse of the system. All classes, rich and poor, belonged to the insurance clubs. The well-to-do paid no more than the poor laborers; and yet, of course, those with social standing or influence received by far the better service.

The physicians of Cuba were not organized into medical societies until the year 1925, when the Medical Federation of Cuba was formed. This organization has grown in numbers and

influence, and has been recognized by many of the insurance societies. The great number of the insurance clubs is a source of weakness, there being thirty-four in Havana alone. The Medical Federation is making considerable progress in five reforms which it is promoting:

- (1) Paying each insurance doctor a salary of at least \$1200 a year.
- (2) Elevating the standards of practice.
- (3) Requiring each insurance doctor to devote an average of fifteen minutes to each patient, instead of less than two minutes as at present.
- (4) Lessening the excessive number of calls which the patients demand (an invariable result of unlimited free treatment).
- (5) Eliminating the methods of super-salesmanship by the insurance solicitors.

Voluntary insurance of medical care is the major plan proposed by the National Committee on the Costs of Medical Care for bringing the services of medicine within the reach of every person in the United States. American physicians will, therefore, be personally interested in all phases of an insurance system that has been in operation in the neighboring island of Cuba for half a century.

Conflicting Medical Testimony

Expert medical testimony given in law courts has a direct relation to the respect and esteem which is popularly credited to the medical profession. A comment by a judge both reveals and forms public opinion. A recent case before the Federal Court in New York City involved a judgment and criticism of not only the defendant at the bar, but also of two medical experts whose testimony was so contradictory that the judge was quoted as saying "Their opinion is entitled to no consideration and I will give it none. I don't accept the experts' testimony. They don't appeal to me as reasonable." (New York Herald Tribune, January 21, 1934.)

This comment might be taken as a sweeping condemnation of expert medical opinion, especially that of disagreeing witnesses. As a matter of fact, it criticised only one phase of

the services of the doctors, as an analysis of the testimony will show.

The point at issue was the health of the defendant both physical and mental, and his ability to confer with his counsel during the trial for his responsibility as president of a large bank which had failed. Medical testimony in the case was proper in order to reveal or disprove the existence of a disease or condition which would not be apparent to a layman; and to estimate the degree of disability besides that which the judge or a layman might have observed. Yet they talked of fine points in the defendant's psychology, using such technical terms as "mental conversion" and "neurotic obsession" which the judge evidently interpreted as plain nervousness such as he could observe by himself.

Moreover, the judge said that the most important testimony was that of the accountant who was in close contact with the defendant during the time of the examination of the books of the bank. Commenting on this testimony, the judge said, "It seems clear that the defendant has sufficient comprehension and memory to be able to testify and to assist his counsel, and to know what it was all about and defend himself if wrongly accused. It is true that he showed a lack of clearness in detail, but a good executive does not concern himself with detail."

The judge was correct in considering the testimony of the two medical experts to be "incompetent, irrelevant and immaterial". When the judge's criticism of the medical experts is analyzed, it will be found to be directed against only one phase of the service rendered by the doctor—that of giving an opinion regarding the degree of disability of the defendant. The physicians had to perform two other phases of medical service before they could render that opinion.

The first phase of the doctors' service was that of making an *examination* according to the ordinary rules and standards of the practice of medicine. It is not at all probable that the two experts differed regarding such basic facts as the action of the heart and the kidneys, the spinal reflexes, or the mental reactions to questions.

The second phase of medical service was that of formulating a *diagnosis* which should express any marked degree of departure from the normal standards as disclosed by the examination. It is not likely that the medical experts differed in their diagnosis of measurable conditions such as pneumonia, nephritis, reflexes, or mental confusion.

The third phase of the services rendered by the experts was the estimation of the *degree* of disability of the defendant, particularly along mental lines. One expert said that his mental processes were impaired, which was probably true considering the anxiety to which the defendant had been subjected. The other expert said that the defendant was sane, meaning that the impairment of his mental process was not sufficient to render him irresponsible in matters with which he was accustomed to deal. Disagreement was not greater than one ordinarily expects between two independent observers.

It is unfortunate that the newspapers gave a wrong impression concerning the scope of the disagreement of the doctors.

Medical Legislation

This is the season for legislation. The lawmakers of most states are now in session, seeking to promote the welfare of the people whom they represent. Among the more important problems which they are considering are those relating to the practice of medicine, including the medical care of the sick and the promotion of health. They are legislating against unwholesome conditions in which the individual may not be aware of danger as unclean milk, occupational hazards and carriers of disease germs.

The 158th session of the Legislature of New Jersey began on January 9 and has considered about 50 bills which have a direct relation to health, in the opinion of the Welfare Committee of the Medical Society of New Jersey. These bills may be divided into three classes:

- (1) Defensive,
- (2) Constructive,
- (3) Economic.

Protection of the Public. The Medical Society is a defense against legislation to lower the standards of the practice of medicine to the detriment of the people's health.

New Jersey has a general Medical Practice Act; but there is a dull monotony in the annual introduction of bills providing for special exemptions in qualifications for healers who profess to practice medicine by the use of certain limited measures. One Senator was reported by the Journal of the Medical Society of New Jersey of December, 1929, as seeking an exemption for a personal friend to practice a peculiar branch of naturopathy. The Brooklyn Daily Eagle of February 15, 1924, published a list of fifty-five healing cults that had been compiled by the Health Commissioner of New York City—and the list has probably been doubled since that time. All these groups are seeking exemptions for themselves, and are even combining for mutual support. The osteopaths who had been granted a special privilege of practicing their own peculiar system of therapeutics are not satisfied to limit their practice to their own methods, but are now seeking permission to use almost any drug, or do any operation, except that they specifically decline to be responsible for a Cesarean section.

The theory of all the exemptions is that the practice of a limited system makes the practitioner so skillful that he is competent to recognize and treat all diseases. If this were true, then every registered nurse would deserve the degree of Doctor of Medicine.

Constructive Legislation. The Medical Society of New Jersey is also promoting constructive legislation which shall raise the standards of the practice of medicine. Its Welfare Committee has worked for months upon a uniform medical practice act which would establish one standard for every person who seeks to diagnose or treat any human ill. The greatest obstacle to the law has been the provision of the Federal Constitution that no *ex post facto* law may be passed; and, therefore, the privilege of practice cannot be taken away from those who are already licensed. How-

ever, the cultists are willing to support the bill provided their present members are permitted to practice essentially without limitation and thereby enjoy a freedom from future competition.

A step toward a uniform medical practice act is the action of the Welfare Committee which will limit the use of the title of doctor to graduates in medicine, dentistry, and veterinary surgery. The passage of such a law in New York State has resulted in the elimination of the title of doctor from the signs and advertisements of the irregular practitioners.

Economics. Most medical bills that are introduced in the Legislature deal with economic phases of medical practice, especially workmen's compensation. A law passed in 1930 gives hospitals the right to secure a lien on any settlement or judgment obtained in public liability cases. An amendment to the act, already introduced, will give a similar right to physicians for medical or surgical services, whether rendered in the hospital or outside.

Methods of Influencing Legislation. A stock argument of the opponents of physicians in medical legislation is that the doctors are interested parties, and that their opinions are biased. Physicians may well consider the methods of other groups who influence their clientèle to write testimonials and send letters and telegrams to their legislators, and attend hearings.

Experience has shown that a dozen business men or social leaders, writing to a legislator, will have a profound effect on his attitude, especially when other legislators receive similar appeals from their constituents. The voice of a representative citizen is sure to reach the ear of the law-maker.

Physicians have a great advantage in that every community has a public health organization whose members will cooperate with the medical society, provided they are invited to help and are given credit for the work which they do. Here is the opportunity for medical societies to enlist laymen in the support of wise medical legislation.

LEROY A. WILKES,
Executive Secretary.

ORIGINAL ARTICLES

PREVALENT MISCONCEPTIONS OF ALLERGY

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Within the past few decades a new and important branch of medicine has come into being, namely, allergy. As has always been the case with new sciences, it has had to struggle for recognition against the profession's characteristic conservatism. The following remarks were prompted by the writer's earlier false notions of the fundamentals of this science and by the average physician's misinformation on the subject. The short history of the development of allergy as a science is a romance in itself. It is a story of several apparently unrelated disorders being brought together and explained by an ingenious and common mechanism, now recognized as a practical application of the principles of immunology.

Of the allergic diseases, bronchial asthma has the longest recorded history. Its clinical picture was quite accurately described by Hippocrates who believed that it was due to peculiar atmospheric conditions. The generic term "asthma" was used indiscriminately through the centuries following to describe any form of respiratory distress. Hay fever is, of course, a misnomer. The condition is neither due to hay or is there any fever associated with it. In fact, one of the distinctive features of allergic diseases is an absence of an increased temperature. The term "rose cold" or "rose fever" is likewise a misnomer, as the pollen of roses ordinarily does not cause allergic coryza, except in some hypersensitive individuals who come in direct contact with the pollen by handling, as in hot-houses. Similarly, goldenrod is a very infrequent cause of seasonal allergic coryza, for the pollen is likewise sticky and heavy, and is not air-borne, but insect-borne for purposes of cross-pollination. The term "atopic" or "allergic" coryza, seasonal or non-

seasonal, is preferable. Seasonal hay fever received comparatively little attention in medical literature, probably because it is a non-fatal condition. However, a case was reported by Botallus in 1565, and Benningerus in 1673 wrote on a clinical condition apparently hay fever. In 1819, Bostock in England read a paper in which he accurately described seasonal hay fever and recognized it as a clinical entity. He ventured the theory that it was due to emanations from hay in conjunction with heat and sun rays. It remained for Blackley, a hay fever victim himself, to demonstrate by a series of experiments beginning in 1856 that in his case, seasonal hay fever was caused by pollen. But a rational conception of the fundamental factors involved was not perceived until the early years of the present century. This was a period when the profession was highly exultant over the possibilities of serum and vaccine treatment of disease. The immunologists had laid the foundation of a science which was the hope of the new century. But the occasional development of serum sickness following the use of therapeutic serum proved somewhat disconcerting, and became the subject of investigation for Von Pirquet and Schick. A few scattered reports of immediate and tragic death in young children following the administration of serum stunned the medical world. Although this cast a cloud of despair among workers, it stimulated explanatory research.

Theobald Smith reported the following observation to that great immunologist Ehrlich, noted while engaged in standardizing diphtheria antitoxin in guinea pigs. If a guinea pig which had been inoculated with horse serum several days or weeks before were again inoculated with a very small quantity of horse serum, serious symptoms, but more often,

death, followed in a few minutes. The quantity used for the second inoculation was in all cases insufficient to cause any symptoms in a control animal. It must, however, be recalled that those human cases which resulted fatally after serum administration had never received serum before. It was, therefore, apparent that as in the guinea pig, there was something in their bodies which reacted with the serum and produced death. In the guinea pig it has since been proven to be a precipitin reaction, causing a tetanic contraction of the smooth musculature, with death caused by asphyxiation by practical closure of the bronchial tree. In the human, precipitins have not been found, but other reacting substances are present in the blood serum as will be shown later.

It was observed that those patients who gave a history of hay fever, asthma, and urticaria, or a family history of these conditions, were more apt to develop alarming symptoms after receiving foreign sera. As early as 1903, Dunbar in Germany conceived the idea that by injecting pollen, a known causative agent of hay fever, into horses, he might produce a hay fever anti-toxic serum as had been done with diphtheria. This serum was marketed as "pollantin" and proved practically worthless. In 1906, Wolff Eisner suggested that hay fever might be an anaphylactic reaction. In 1911, Freeman and Noon began the treatment of hay fever with pollen extracts. It remained for Prausnitz and Küstner in 1921 to demonstrate that the mechanism of allergic hypersensitiveness was mediated through specific sensitizing substances in the blood serum of allergic individuals. These skin sensitizing antibodies were given the name "atopic reagins" by Cocoa and Grove. These reagins are as a rule multiple in number (one for each substance to which the allergic persons is sensitive), specific in nature and predestined by heredity. Curiously enough, even the age of onset of an allergic condition in an individual is predetermined by hereditary factors. This is contrary to the popular notion that asthma and hay fever date back to a chest infection or to a severe cold. When obtained in the history, coincidence plays a psychological rôle. The problem of allergic diseases has since re-

ceived considerable attention by unheralded workers with gratifying results.

For the following clarifying definitions I am indebted to Dr. Spain. The term "hypersensitiveness" is an expression used to describe an altered reaction in both man and animals to minute amounts of a substance, usually protein. The animal form of hypersensitiveness, which differs considerably from the human, is called "anaphylaxis"; while in the human being it is called "allergy". Experiments on lower animals have shown them to be highly refractory to allergic diseases. This is more readily appreciated when one considers the fact that allergy has been found to be an inherited hypersensitiveness to certain substances, technically called antigens. Specific sensitizing antibodies are present in the blood serum for each substance. The specific nature of these reacting substances has not yet been determined and will require a revision of Ehrlich's side chain theory of immunity.

It must be emphasized that asthma and hay fever *per se* are not disease entities, but should be regarded as the same condition in different sites. A similar analogy would be carcinoma of the stomach and carcinoma of the colon. For success in treatment, the patient must be viewed primarily as an individual possessed with an allergic state. This allergic state obtains in about 7 per cent (Coca) of the population. It is passed from parent to offspring apparently in accordance with the Mendelian Law of Heredity. While an allergic individual may have hay fever, he is potentially susceptible to asthma or some other allergic disease. Thus far, several such diseases have been classed together. In a rough order of frequency and relationship they comprise hay fever, asthma, allergic coryza, urticaria, allergic eczema, allergic headache, neurodermatitis, angio-neurotic edema. Many patients who complain of continuous or frequent colds during the year with a clear watery nasal discharge are cases of allergic coryza, synonyms of which are vaso-motor rhinitis, hyperesthetic rhinitis, and non-seasonal hay fever. These patients are refractory to the usual methods of treatment. I have seen physicians victims of this condition who believed they suffered from chronic colds or sinusitis. Chronic sinusitis is

often a secondary factor brought about by the continuous congestion of the nasal mucosa. The site or tissue which will be involved in a given allergic individual depends on his particular "weak spot" or more technically his "shock tissue site". The initial and basic tissue pathology is the same throughout, namely edema. The later pathology is secondary in character. The symptoms differ only because of the variation of site. Thus, if the patient's shock tissue happens to be the nasal mucosa, he will develop hay fever or allergic coryza; if the bronchial mucosa, he will develop bronchial asthma; if the mucosa of the gastro-intestinal tract, he will develop symptoms of gastro-enteritis or appendicitis; if the skin, he will develop allergic eczema. The same mechanism may obtain in the meninges with resultant allergic headache. The busy physician is apt to overlook the fact that the first sign of an allergic manifestation may be hematuria, hemorrhage from the bowel, cystitis, dyspepsia, dysmenorrhea or other so-called "essential" symptoms which cannot be explained by the usual mechanisms.

Having determined that a patient is allergic, the problem of specific diagnosis presents itself. The pessimism of the average physician regarding this is due to the prevalent notion that a series of skin tests is the only method available for diagnosis. This is quite contrary to fact. The usual result of such a belief is that the patient is allowed to drift toward patent medicines undiagnosed, or he is treated with one or two substances showing skin reactions which are not the cause of the patient's symptoms. It may be well to state at the outset that in most cases about half the time should be spent in hunting down all foci of infection. It is now a known fact that mild foci of infection, which in the non-allergic person are of little consequence, may be of paramount importance in the resultant treatment of allergic cases. Failure to clear up foci of infection completely will prevent the patient from receiving the full benefit of allergic treatment.

Now as to skin testing. It so happens that

the atopic reagins in the blood serum have skin sensitizing properties. These properties are either not shared by all reagins or are shared to a varying degree depending on the type of antigen. Some skins may be so hypersensitive that practically one-half or more of the antigenic substances will show up as positive. It is reasonable to assume that the patient is not clinically sensitive to so many substances, and by clinical test this assumption is substantiated. This difficulty is overcome by injecting the allergic patient's blood serum into sites in a non-sensitive individual's skin and using these sites for testing. The allergic serum "fixes" itself to the non-sensitive skin sites within a few hours, sensitizing the skin locally and temporarily. The sensitization thus produced can be demonstrated for several weeks. Thus only those antigens for which there are reagins in the patient's blood serum will cause a reaction with wheals and pseudopods. Unfortunately, the controversy as to the relative efficacy of cutaneous or intra-cutaneous technic must be injected here, but suffice it to say that (Dr. Spain) of a series of 100 allergic cases, 80% showed positive reactions by the intracutaneous method and 60% by the cutaneous method. I feel that the figure for the cutaneous method given is very liberal. Another reason why skin tests alone are not reliable is that in some cases it is not the substance applied to the skin that produces symptoms, but a split product thereof produced after ingestion. The skin, therefore, is only an aid in diagnosis, and must be looked upon in the same light as any other laboratory procedure in arriving at a conclusion.

The second method of testing is by ingestion and elimination of suspected edible antigens. This is especially useful in allergic skin conditions and gastro-intestinal disorders. Careful observations are made over a reasonable period of time after addition and withdrawal of individual foods from a basic non-antigenic diet. The ophthalmic test is used for a few antigens when a very accurate test is sought. This consists of an instillation of a drop or two of the properly diluted antigen into the conjunctival sac of one eye. Of course, after

one positive test the eye cannot be used for further testing until the reaction has subsided. The patch test is used for certain antigens like poison ivy, which cause contact dermatitis, or when the antigen is a chemical or substance which it would be unwise to inject into the skin. This, as its name implies, consists of the application of the properly moistened antigen against the skin, covered with adhesive tape. The antigen is removed and the reaction read in twenty-four hours.

As for extracts, a very comprehensive literature is available, but it must be pointed out that commercial extracts for testing are as a rule too weak for accurate work. This casts no reflection on the quality of the preparations, but is the consequence of a few disastrous results following the use of more potent products or extracts which the inexperienced physician failed to dilute to proper strength. The result is that, according to one observer, they are only about 40% efficient. Liquid extracts must be clinically tested from time to time to check their potency, as a source of poor results is the use of deteriorated extracts. The best results, of course, are obtained by the use of extracts made by the physician himself or under his personal supervision; a method which is employed by those men who specialize in this branch of work.

Now as to treatment. Poor results follow cursory treatment. Wherever possible, eliminative treatment is ideal. In other words, the removal of the specific antigenic substances from the environment of an allergic individual gives prompt and dramatic relief. The difficulty encountered in active treatment with antigens is due to the fact that one is endeavoring to influence an hereditary character—a procedure which in some cases is biologically impractical. On the other hand, when the excitants cannot for practical reasons be removed from the environment, hyposensitization or partial desensitization is attempted. Technically, this consists of a gradual neutralization of reagins in the blood serum. The results in conjunction with complete eradication of foci of infection will vary from mild improvement to practically permanent relief. The

treatment must be thorough and painstaking—facts which are not generally appreciated. Contrary to some notions, there are no standardized methods of treatment. Each patient presents a specific immunological problem. The immunity conferred varies from evanescent to, for practical purposes, permanent. It is usually short lived, but each series of injections strengthens the conferred immunity within limits.

The necessity for early treatment of allergic conditions as hay fever and asthma is vital. Untreated cases develop secondary pathological changes which make satisfactory treatment stubborn and trying to the patient as well as the physician. The edematous nasal mucosa closes the sinus orifices, preventing aeration and drainage with sinus infections. The asthmatic patient develops an infectious bronchitis. Old cases often develop dilatations of the bronchi with bronchiectatic cavities and destruction of the alveoli of the lung. A smaller number of cases may show the effects of heart strain. The common allergic diseases are not fatal, but are economically disabling and may make the patient's outlook on life a miserable one indeed. He may well be called the "forgotten patient". His faith in orthodox medicine slowly dwindles. His morale becomes undermined, especially when he is given little hope of relief from an uninformed physician. Many drift to patent medicines or quacks and to different suggested climates and altitudes, dissipating their life's savings fruitlessly. Many so-called hay fever resorts are more fancied in effect than real. Patients suffering from hay fever and asthma due to pollen will get seasonal relief if sent to a geographical area where those particular plants, trees, or weeds do not flourish. Humidity plays a minor rôle except that asthmatics usually feel slightly worse with a high humidity. Some asthmatics have been sent to the mountains where, as a rule, they feel worse due to the rarified atmosphere.

The successfully treated patient is one of the most grateful the physician is called upon to treat, and each case is a new challenge to his ingenuity.

STUDIES OF THE SMALL INTESTINE

By KARL KORNBLUM, M.D., Philadelphia, Pa.

During the past twenty years roentgenologic studies of the small intestine have been conducted from time to time by various members of the Radiological Department of the Hospital of the University of Pennsylvania. This portion of the gastro-intestinal tract has seemed to us a fertile field for investigation. Of the entire alimentary canal, the physiology and pathology of the small intestine is, from the point of view of the clinician and roentgenologist, the least understood, and it is, no doubt, for this reason that diseases of the small intestine apparently have been more or less neglected in clinical medicine. The small bowel has not attracted, to the same extent, the clinical investigations that have been directed toward the stomach or colon. The obvious reasons for this are to be found in the facts that organic lesions of the small intestine are relatively uncommon and means for the satisfactory study of this portion of the digestive tract were not readily available before the introduction of the roentgen ray.

The roentgen examination affords the best method for the routine study of the small intestine, yet the value of this procedure has not been fully recognized, not even by the radiologist. The reason for this is the fact that the roentgen examination and the interpretation of the findings in the small bowel are the most difficult of any portion of the gastro-intestinal tract. The appearances to be encountered are so variable that it is only after considerable experience and after special attention has been given to the jejunum and ileum that the changes indicative of disease can be detected and their significance appreciated. The average radiologist in his routine gastro-intestinal examination is usually content with the fact that no gross obstruction has occurred to the passage of the opaque meal through the small bowel. While it is true that obstruction is the cardinal roentgenologic sign of small intestinal disease, there are minor degrees of obstruction which are also significant that will not be detected in a cursory examina-

tion. In addition, there are other manifestations aside from obstruction which are of importance.

It is admittedly difficult roentgenologically to detect abnormalities in the small intestine, but the recognition of the cause of such abnormalities presents a still more difficult problem. At times one must be content with the mere detection of some abnormal condition without attempting an interpretation in terms of pathology. It is often impossible to know whether or not a given alteration is the result of a primary condition in the small intestine, or is secondary to some pathological process elsewhere. Bearing in mind the fact that primary lesions are uncommon, one can expect that most abnormalities will be secondary to lesions elsewhere. Being free to move about in the peritoneal cavity by virtue of its length and mesenteric attachment and because of its position between the stomach and the colon, the small intestine finds itself indirectly affected to some extent by almost every morbid condition occurring in the abdominal or pelvic cavities. Under the circumstances, it is indeed surprising that more serious alterations in the small bowel are not more frequent. The difficulty in recognizing the cause of abnormal appearances in the small intestine is enhanced by the fact that the roentgen manifestations are frequently quite similar regardless of the primary cause. Thus it becomes necessary to correlate the roentgen findings with those obtained in the examination of the rest of the digestive tract. It is to be remembered that the alimentary canal has been divided into several distinct portions largely for ease of anatomical description. Physiologically, however, the tract functions as a whole, and dysfunction in one portion is certain to have some influence on all other parts. In addition, there must also be a close correlation of the roentgenologic findings with the clinical manifestations of the patient. It is only after such correlation that many abnormalities to be seen in the small bowel can be interpreted with any degree of accuracy.

Another important reason for the inability

clinically to recognize disturbances in the small intestine is the fact that they produce no typical symptoms or physical signs. There is no characteristic clinical picture as is seen in peptic ulcer, gall-bladder disease, or appendicitis. Symptoms are often of a vague, indefinite nature such as are frequently associated with lesions in various parts of the abdomen. Positive physical signs are usually absent. These patients are, therefore, frequently labeled with a diagnosis of chronic dyspepsia or nervous indigestion and must content themselves with the usual unsatisfactory therapeutic results obtained in such cases. There can be little doubt that in some anatomical or physiological disturbance in the small intestine is to be found the origin of the symptoms of many gastrointestinal patients whose condition has defied medical diagnosis. A thorough roentgen examination of the digestive tract with special attention to the small bowel should do much toward solving the diagnostic problems presented by this large group of patients. It becomes the duty, therefore, of every radiologist to acquaint himself with the anatomy, physiology and pathology of the small intestine and to apply such knowledge to the roentgenologic study of this portion of the alimentary canal. It should be emphasized that considerable experience is necessary in the roentgenologic observation of the small intestine not to be confused by the great variety of appearances to be encountered.

There are many different methods employed by radiologists in the roentgen examination of the gastro-intestinal tract, so it is needless to say that everyone will adopt for himself an individual method for studying the small intestine. Regardless of details, it is essential that such an examination be carried out in a definite and methodical manner. There are a few points in the examination that are worthy of special attention. Throughout this discussion reference to the small intestine includes only the jejunum and the ileum. In the average patient the study of the small intestine can be carried out along with the routine examination of the stomach, duodenum and colon. As in all portions of the alimentary canal the fluoroscopic observation is the most important part of the examination. Sufficient time must

be given to the fluoroscopic observation to permit the contents to fill the first few feet of the jejunum. If this is not done, abnormalities are likely to be missed as most primary lesions are located in the proximal jejunum. Films should be made of the particular portion of the bowel involved and in the position most advantageous for a satisfactory demonstration of the lesion. While it is true that the patient's history is usually of little value as far as the small intestine is concerned, nevertheless, occasionally the symptoms will direct one's attention to the small bowel. In every case, therefore, one should determine from a perusal of the history whether or not the suspected pathological process is likely to be in the small intestine. If such is the case, the routine examination should be altered somewhat. The progression of the opaque meal through the tract should be observed at hourly intervals or more frequently if deemed advisable. Such observations should be continued until the meal has reached the cecum or until the small bowel has completely emptied itself of the opaque material. It is essential that these observations be made both in the recumbent and the erect positions. The latter is of particular importance for the detection of fluid levels which usually denote some degree of obstruction. Other features of the examination are more or less obvious and will not be dealt with in detail.

One of the earliest studies in our department was made by Drs. Pancoast and Hopkins in 1915, on the effect of some opium derivatives on the gastro-intestinal tract of man. In these investigations it was found that morphine had a decided effect in some individuals in retarding gastro-intestinal motility. In the stomach there was produced a variable degree of pyloric spasm, increased peristalsis and a decided prolongation of the emptying time. The effect upon the small intestine almost invariably was a decrease in motility which was apparently the result of a lack of propulsion rather than of spasm. This effect was most noticeable in the upper small bowel. In the large intestine the effect of morphine was quite variable and probably of little consequence. It was found that the effect produced by morphine varied considerably in different individ-

uials dependent, no doubt, upon individual susceptibility. Females appeared to react more readily than males. There was observed no distinct uniformity in connection with dosage, small doses in some individuals being more effective than much larger doses in others. No distinction was noted in regard to the oral administration as compared with the subcutaneous injection.

The effects of morphine have been repeatedly observed by us in our routine gastro-intestinal work. The small intestinal stasis thus produced gives rise to a rather characteristic appearance on the roentgenogram. This consists in the collection of the opaque medium in the loops of the small intestine which are massed together in one portion of the abdomen. The individual loops are of normal calibre and there is no evidence of spasticity. Fluoroscopically little movement can be seen, peristalsis being extremely sluggish. The appearance is quite striking when contrasted with that obtained after the effects of the morphine have disappeared. Similar results are, no doubt, produced by other drugs in susceptible individuals. We have observed it frequently following the use of luminal and occasionally with codeine. Unless familiar with this effect of certain drugs upon the gastro-intestinal tract, one may be misled by what is found in the roentgen examination.

In 1927-28 the writer made a special study of small intestinal stasis, describing the roentgenologic appearance and classifying the condition on an etiological basis. In this study it was found that two distinct types of stasis could be recognized; that which occurred in the terminal ileum as the result of lesions in the region of the ileo-cecal valve, and that which manifested itself as a generalized stasis throughout the small intestine. In the latter group a large variety of conditions were found which could produce this type of stasis. It is in the recognition of the cause of small intestinal stasis that considerable difficulty is encountered and it is here that the closest possible correlation between the roentgenologic and clinical manifestations becomes so essential.

In this study special emphasis was placed upon the small intestinal stasis to be found in

patients with malignant disease. Such a finding will at times indicate the presence of metastasis to the peritoneum or to the lumbar or mesenteric lymph nodes. However, as was pointed out at the time, another factor must be taken into consideration. We suspected and have since convinced ourselves of the fact that small intestinal stasis is almost invariably found in all debilitated states. It is commonly seen in tuberculous patients in the absence of tuberculous involvement of the intestinal tract. It will be found in patients recovering from a prolonged illness. There can be little doubt but that the debility that often accompanies malignancy is in most instances responsible for the small intestinal stasis to be found in this group of patients. It would seem that stasis, the result of general physical debility, is of nervous origin due to a lack of intestinal tone and depressed peristaltic activity. The similarity to the retarded gastro-intestinal motility as seen in neurasthenia would tend to support this inference.

Attention should be called to the influence of physical activity upon intestinal motility. In patients who are confined to bed there is usually observed a definite generalized small intestinal stasis. Often such confinement is the result of weakness and general debility, under which circumstances delayed gastro-intestinal motility would be anticipated. There are times when confinement to bed or restricted physical activity is not accompanied by general debility. In such individuals small intestinal stasis is not usually encountered. The state of the patient's physical activity in itself would, therefore, appear to have little influence on gastro-intestinal motility.

Reference has been made to the physiological dependence upon each other of the various portions of the gastro-intestinal tract. What influence does an alteration of motility in one portion of the tract have upon the motility of others? This question presents a very complex problem and one which has been the source of much controversy. Obstructive lesions in the colon will, of course, tend to produce stasis in the small intestine dependent upon the proximity of the lesion to the ileocecal valve and the degree of obstruction. This is, of course, purely mechanical and gives rise

to what has been termed ileal stasas, in which there is a delay of contents in the terminal ileum. Generalized small intestinal stasis is not usually seen in such cases, thus indicating that there has been no appreciable change in small intestinal motility. Likewise, in cases of marked constipation, which the radiologist is so frequently called upon to examine, it is not often that one observes any appreciable delay in the passage of the contents through the small bowel.

What influence does the motility of the stomach have upon small intestinal motility? An increase in gastric motility usually results in a more rapid progression of the meal through the small intestine. This is as one would anticipate. Sudden distention of the intestine acts as a stimulus to peristaltic activity. The over-distention of the upper jejunum caused by the rapid outpouring of contents from the stomach is as a rule accompanied by rather vigorous peristalsis in the small bowel so that the contents reach the cecum sooner than occurs normally. An excellent example of this is seen in patients with a gastro-enterostomy in whom the entire opaque meal is commonly observed in the small intestine within a half to three-quarters of an hour after ingestion, and in four to six hours the head of the meal frequently is found to have progressed as far as the sigmoid colon.

Of what influence is delayed gastric evacuation upon small intestinal motility? As long as the stomach is eliminating contents this will be found scattered irregularly throughout the jejunum and ileum. While this appearance may simulate generalized small intestinal stasis, such an interpretation is not warranted unless the size and shape of the opaque masses are distinctly abnormal. Therefore, care must be exercised in the interpretation of small intestinal stasis in the presence of a gastric residue. In cases of gastric hypomotility there will usually be observed the collection in the terminal ileum of the major portion of the contents that have left the stomach. This would indicate that there has been no alteration in small intestinal motility as the result of delayed gastric evacuation. From our roentgen observations, therefore, we are of the opinion that gastric hypomotility has little or no influence upon small intestinal motility.

Does the motility of the small intestine have any effect upon the rate of gastric evacuation? In the roentgen examination of the gastro-intestinal tract considerable significance is attached to the presence of a four or six-hour gastric residue. If this is more than slight in amount, it is usually indicative of some definite pathological process. Such a residue may denote a lesion of the pylorus, duodenum or stomach or may result from a marked pylorospasm. We have frequently been surprised to find a gastric residue of considerable amount in patient in whom our examination of the stomach and duodenum had been entirely negative. In such cases there will be found, of course, opaque contents scattered throughout the small intestine and, as has been mentioned, it is difficult under such circumstances to detect a true small intestinal stasis. In searching for a cause of the gastric residue the question has naturally arisen as to whether or not we are dealing with a definite delay in small intestinal motility which has secondarily resulted in a delay in gastric evacuation. We have observed this sufficiently often to believe that hypomotility in the small intestine will produce a hypomotility of the normal stomach. This is in agreement with similar observations made by others both in clinical and experimental studies. This influence upon gastric motility would appear to be similar to but much less in extent than that exerted by the duodenum. Recent work by Cohen and Shay has emphasized the importance of this effect which is believed by them to be exerted directly upon the pyloric sphincter. From our own roentgen observations and from the studies of others, it would seem that the motility of the small intestine is surprisingly independent of the motility of the rest of the gastro-intestinal tract. The duodenum would appear to be the pacemaker for gastro-intestinal motility. This influence is no doubt shared by the upper small bowel, becoming less evident as the ileo-cecal valve is approached.

The roentgen examination of the small intestine is probably most frequently done for the detection of an intestinal obstruction. The difficulty in this examination is not so much in recognizing the existence of an obstruction as in determining the part of the bowel involved. For this purpose one must depend

upon the anatomical peculiarities of the various portions of the intestine as regards morphology and position. The characteristic appearance of the various parts of the gastro-intestinal tract is well shown in Fig. 2. The large size, the fixed and fairly constant position and the characteristic haustral markings enable one to distinguish with little difficulty the large from the small bowel. The stippling of the proximal jejunum and the serrations of the valvulae conniventes are an aid in the recognition of the jejunum from the clumped and



Fig. 1. The characteristic appearance of various portions of the gastro-intestinal tract: a. Stomach. b. Stippling of the proximal jejunum. c. Serrations due to the valvulae conniventes of the jejunum. d. Ileum. e. Cecum. f. Transverse colon.

tubular appearance of the ileum. In intestinal obstruction these features, so characteristic of the normal bowel, become considerably altered. One can no longer rely on the size of the bowel since the small intestine may distend to such an extent as to be indistinguishable from the colon. For this distinction, chief reliance has been placed upon the presence or absence of haustral markings. Pendergrass, however, has called attention to an appearance of haustrations in the distended small intestine indistinguishable from those seen in the colon. No doubt these haustrations represent a persistence in the distended jejunum of the

normal serrations produced by the valvulae conniventes.

Recently in the Gastro-Intestinal Clinic of the University Hospital, Miller and Abbott have devised a method of obstructing any portion of the small intestine by means of a small rubber bag attached to a tube. In addition, the tube will permit the removal of secretions or the injection of fluids into the bowel. This tube has been used chiefly to facilitate study of the duodenum. In those cases in which the routine roentgen study of the duodenum has been somewhat uncertain or inconclusive, the use of this tube has enabled us to visualize the duodenum so satisfactorily, especially the cap, as to leave little doubt whether or not a lesion is present. The use of this tube is as applicable in the remainder of the small intestine as in the duodenum and should prove of inestimable value in the detailed study of this portion of the gastro-intestinal tract. As indicated, it permits at the same time a study of the contents of the particular portion of the bowel under investigation. The results of this work are to be published by Shiffer.

Further studies on the small intestine are in progress at the present time by Pendergrass and Abbott. They are investigating the effect of various drugs upon the small bowel by a combination of roentgenographic observations and kymographic tracings of intraintestinal pressure. This latter is accomplished by a specially devised balloon attached to a long rubber tube of small calibre. The balloon is permitted to lodge in various portions of the small intestine. With the balloon distended and connected by means of the tube to a kymograph, tracings are obtained indicating variations of intestinal tone as produced by various drugs. Discrepancies in the results of similar experiments on animals and humans have prompted this investigation.

Our present knowledge of small intestinal physiology leaves much to be desired. During the past few years there has been a general quickening of interest in this portion of the gastro-intestinal tract and the roentgen ray has been in no small measure responsible for this. As a result many patients will be rescued from undiagnosed and improperly treated gastro-intestinal conditions.

CHRONIC NON-TUBERCULOUS RENAL INFECTIONS

ALEXANDER RANDALL, M.D., Philadelphia, Pa.

The introduction of a new medical concept is always too comprehensive in its scope and too all-inclusive. It is the rule that later mature study has to separate such an entity into its true component parts. Examples of this are legion in medical history. The true milestones of progress are classic, monographic studies where loosely used terminologies have been separated into their proper pathologic groupings with an accompanying clearer understanding of the clinical whole. Such was the work of Richard Bright on renal disease, Gerhard on fever, Graves on goitre, Ricard and Bell on venereal disease, etc. Such studies are not always right in their final analysis; nevertheless, such dividing and subdividing, with more intensive studies of the individual component parts, is one of the most lucrative modes by which progress in the knowledge of medicine is attained. Often the explanations found to be of value and of truth in the understanding of one simple group, can subsequently be transposed to aid in appreciating the pathologic states of more complicated groups.

Today, I approach the subject of renal infection with diffidence, fully appreciating the scope of the subject. We will start by excluding certain well-recognized pathologic states, and then try to apply certain simple factors that are recognized as of etiologic importance in some of these pathologic conditions, to a better understanding of the more obscure.

The infection of the kidney with the tubercle bacillus can at once be set aside as a story of its own. We know its etiology, pathogenesis, pathology, diagnosis, and are of one mind as to its treatment. The acute surgical kidney (or acute hematogenous nephritis), is likewise to be so disposed of; its picture has been understood since Brewer's classic work. Abscess of the kidney, and carbuncle of the kidney, are separate chapters in a monographic study on renal infections that today we will omit. Fin-

ally, having passed by the toxic nephritides, and the rare invasions such as actinomycosis and echinococcus, let us take stock of what is left and analyze what we know concerning it.

This division leaves us with those two closely allied conditions: pyelitis and pyelonephritis. It is truly a misfortune that rarely do these two conditions come early to the operating or the post-mortem table. When they do arrive it is not until the lesion is so far advanced as to make it difficult to recognize its mode of onset and its trend of progress, or to separate its early clinical manifestations from the late ante-mortem complications.

It is the thought of today that these two conditions, pyelitis and pyelonephritis, are one. We cannot recognize, either clinically or histologically, a pure case of either of them, without some complicating features of the other. Today I will likewise treat them as one condition for I have repeatedly tried in clinical study to look for one and always have had to conclude that both were present. Therefore, my first message to you is, to absolve from your mind the common usage of that clinical term "pyelitis". This term, pyelitis, facetiously called a diagnostic blanket, has crept into our medical nomenclature to more or less signify the chronic, milder, non-tuberculous, non-surgical, renal infections. To be sure, it may show markedly acute exacerbations and its primary onset is generally an acute febrile condition. As a diagnostic term it "has attained the dignity associated with old age" and stands today as "the stronghold of the ascending infectionist principally because of the delightful simplicity of the assumption" (Cabot).

That I may not be misunderstood, let me state that I concur in this conception that clinically, at least, these two pathologic terms, pyelitis and pyelonephritis cease to be dual; that for all clinical purposes they are one; and that I will hereafter use the word pyelitis as synonymous with pyelonephritis.

There are some who yet adhere to the idea

that the ascending paths for the infection to reach the kidney is the rule. Though one is willing to admit that such does occur under certain conditions of peripheral obstruction or neurogenic dysfunction in the lower urinary tract, there are certain factors that have been so frequently pointed out in support of the hematogenous route that it seems strange this is not more generally acknowledged today. For instance, it is generally accepted that pathogenic and nonpathogenic organisms can, and frequently do, pass to and through the renal system into the urine. Again, it is recognized that blood-borne cocci show a predilection for colony growth in the renal parenchyma, and bacilli show a similar predilection for pelvic localization. Further, there are careful clinical studies which have shown that the onset of an acute attack of so-called pyelitis is preceded by a bacteriemia; proven, in one study, in 117 out of 120 cases. This bacteriemia is followed by an albuminuria; then by a bacilluria; and 5 to 6 days later occurs a pyuria.

Such is the well-recognized acute pyelitic infection, on which there is general agreement. Few physicians worry about the acute primary attack—it is often sharp and quickly over; in fact, it is the consistency of this acute disease that makes it stand out as a clear-cut clinical entity. Because of the purity of this picture, one fails to be able to correlate it with the ambiguity of its mate, the so-called chronic pyelitis.

Setting aside this clear-cut entity of acute pyelitis, let us try to visualize chronic pyelitis more clearly. Here we have the persistent pyuric patient, the type of patient who for months, even years, is diagnosed as and treated for chronic pyelitis. He frequently presents the mildest of febrile reactions and has as the major symptom what the French picturesquely called, a leukocyturia. In this group will have to be included the child or adult, who at indefinite intervals presents true acute exacerbations, but between which, is never completely symptom-free. In fact it is the persistent repetition of this disagreeable episode that taxes one's imagination to competently visualize the pathologic process present. One's limit in therapy too often is reached and strained to the break-

ing point when mother, or even the patient himself, asks what can we do to get him well and make him stay well. Especially is this true when the interested one sees each attack taking more and more out of a dwindling reserve of strength, or bodily and mental growth being stunted by recurrent ill-health. It is in such cases, when the outcome is spoiled by the failure of complete return to normal, and when perhaps only the urine continues to show the presence of pus cells, or a slight evening pyrexia refuses to disappear, that it behooves us to know more about what is latent.

Clinically, we have 3 separate and definite groups to which we apply the term pyelitis: (1) the pyelitis of adult life, (2) the pyelitis of infants, and (3) the pyelitis of pregnancy. I intend to consider them in reverse order; it being the reverse of the order of frequency in which this clinical diagnosis is made.

In the pyelitis of pregnancy we have, without question, an acute pyogenic infection of the renal collecting funnel. I do not believe anyone claims that it is an ascending infection in these cases. You, of course, know that 40% of these patients go to premature delivery; that in 70% the bacillus coli communis is the infecting organism. Let me add, that we now know, through intravenous urographic studies, that 99% of all normal pregnant women have, to an actual demonstrable degree, dilated ureters; that 85% of these are right-sided and only 15% left-sided; and that this matches up with the equivalent occurrence of right-sided renal infection in the pyelitis of pregnancy. I do not want to debate why and how pregnancy obstructs the ureter; it is quite sufficient that we admit—as I am sure we do—that here we have a clear-cut picture of mechanical obstruction, faulty drainage, and, in certain cases, an implantation of infection. This is as clearly an infectious surgical entity as an acute empyema of the gall-bladder. And what is its clinical course? Drainage by catheter or pyelotomy, subsequent satisfactory delivery of the mechanically obstructive factor, the pregnancy, followed by a return of normal drainage, and the catheter may be done away with or the pyelotomy will spontaneously heal. The patient recovers completely. This, then, is the simple picture in which one sees the soil

prepared, the seeds of infection planted, and a harvest gathered that only "the grim reaper" himself cares to garner, if surgical intervention by competent drainage is not promptly instituted.

May we not, with this clear-cut picture as a background, look upon the other case groups of so-called pyelitis with greater discernment and try to interpret them upon similar grounds? I do not argue that acute pyelitis in infants does not arise from distant foci of infection, such as the bowel, the tonsils, etc. Such they do and the clinical picture is quite clear. They run an acute course that is quite typical, end promptly and get well to stay well, on general and local measures directed to the source. But the chronic case, or the "repeater", recurring without primary disturbance in bowel, tonsils, or elsewhere, is, to me, quite obviously the patient in whom the soil unfortunately has been previously prepared. Once infected, the trouble is easily perpetuated due to local abnormalities that essentially produce faulty drainage. This is my thesis.

In the occasional case of pyelitis in the adult, the picture is essentially the same as in childhood, though the possibility of soil preparation enlarges to a considerable degree.

And what may such abnormalities be that cause poor urinary drainage? Congenital failures, such as faulty ascent and rotation of the kidney; congenital anomalies, such as double pelvis, horse-shoe kidney, solitary kidney, infantile kidney and renal ectopy and dystrophy. Horse-shoe kidney occurs, 1 in 700 normal cases; polycystic disease 1-300; ectopy 1-5000, other grouped anomalies 1-200; supernumerary vessels in from 30 to 56% of all normal persons; double ureters in from 3 to 4%; abnormal ureteral narrowing, especially at the uretero-pelvic junction. There occur also, ptosis of the kidney; kinks of the ureter; diverticula; and pressure from vesical or pelvic organs. Hirst demonstrated anomalies in his post-mortem series to occur 1 to 20. Helmholtz, in his chronic pyelitis cases could recognize and demonstrate the presence of anomalies in one out of every three children.

In the adult we have the reflection of the infant. Some of these lesions may improve with growth, others with equal likelihood will

grow worse; but into the adult picture may appear traumas, peripheral vesical obstructions and genital infectious complications with adnexal disease, both female and male.

CONCLUSIONS

These, then, gentlemen, are my theses for your consideration:

(1) That blood borne infections causing pyelonephritic lesions do occur, presenting an acute disease which, after a brief course, promptly gets well and stays well.

(2) That in the pyelitis of pregnancy we have a distinct picture typical of soil preparation plus infection, and in which a return to normal drainage is promptly followed by cure.

(3) That in the chronic pyelitis of infancy, childhood and adult life, again we should look for, and expect to find, similar soil preparation whose mere existence allows perpetuation of an infection.

(4) That too often procrastination robs the ultimate investigator of such an opportunity, as the true picture has been destroyed by progressive pathologic changes.

(5) That today, urology offers competent and safe methods of investigation at all ages of life, especially brilliant being the means of studying the normal or abnormal physiologic functioning of the urinary tract as a whole by intravenous urography; it becomes urgent, therefore, that these cases be brought early to competent investigation before structural damage requires diagnostic and remedial measures which tax the utmost skill of the clinical urologist and surgeon.

DISCUSSION

Dr. Edgar A. Ill (Newark): Ten days before this meeting, I wrote Dr. Randall and asked him for a copy of his paper; he wrote me a short note and said he was going to speak extemporaneously. He gave the impression he was not going to prepare his paper. He covers his subject so completely and he is such a keen pathologist and investigator, nothing is left to say. I do want to say that I think at this point Guy Hunner's name should be mentioned as having done a great deal of the original work on obstructions in the ureter. I spent a lot of time with him in Baltimore 20 years ago and I saw many of his cases of chronic pyelitis completely and satisfactorily cleared up by dilatation of the strictures. As you know, he does that with a catheter and a wax bulb.

I have 3 slides which I want to show which con-

firm what Dr. Randall has said—that chronic infections are due to lack of proper drainage. That is nothing new in this principle because lack of proper drainage in the stomach from obstruction of the pylorus and lack of proper drainage in the rectum produce the same kind of infection, and the kidney is just another part of the body.

(Slide.) This is an obstruction in the ureter from carcinoma of the cervix. This woman was treated for cancer of the cervix uteri. She had pain in her side and I thought it was due to recurrence of the cancer. As a matter of fact, she had pus in her urine and investigation showed this to be pyelitis from obstruction, from carcinoma of the cervix. Here you see the contraction of the tissue following the treatment. These patients die from infections of the kidney. Therefore, pain after a patient gets well from cancer of the cervix should be investigated.

(Slide.) This is pyelitis in pregnancy. This woman for religious reasons refused an abortion which was urged upon her. She was sent to me and I took care of her by drainage with a catheter.

(Slide.) This shows this same patient; you will notice the great difference in the size of the kidney, pelvis and so on. She is today free from pus.

Dr. C. H. deT. Shivers (Atlantic City): I have enjoyed listening to Dr. Randall's paper and have profited much by what he has said. It is difficult to discuss a subject that has been so completely covered but I will endeavor to emphasize some of the high points. First, I agree with Dr. Randall that it is impossible from a clinical standpoint to differentiate between a pyelitis and a pyelonephritis; therefore, I consider it best to class all these infections of the kidney under the term of pyelonephritis.

Dr. Randall has purposely omitted acute renal infections except to eliminate the conditions by mentioning their existence. The etiology of renal infections has always been one of special interest to me. Our conception has been that most of these infections are blood-borne, although we have always kept in mind the possibility of lymphatic extension and direct extension up the lumen of the ureter. The latter may be especially true in those patients with a chronic incomplete urinary obstruction. This is well illustrated in some cases presenting chronic small caliber stricture of the urethra, where we may find on examination one or both kidneys infected, with or without hydronephrosis.

I was very much interested to note in visiting Von Lichtenberg's clinic in Berlin that they consider the etiology in most cases of renal infections, due directly to infection of the male and female genital organs with secondary lymphatic extension to the kidney. Since that time I have carefully studied several groups of cases suffering from chronic upper urinary tract infections with the purpose of determining the presence or absence of associated infection of the cervix in the female and the prostate and seminal vesicles in the male and while the evidence seems to point to a correlation of these infections, we have been unable to prove

this connection by cultural studies in a sufficient number of cases to establish this contention on a scientific basis.

We have all seen cases of pyelitis or pyelonephritis in young women shortly after marriage, where the source of infection was probably the cervix secondary to traumatism produced by coitus. Unquestionably a certain number of renal infections are directly due to lymphatic extension, but we feel from our experience the greatest number are blood-borne.

I am glad to hear Dr. Randall emphasize the importance of careful urinary investigation by cystoscopic and x-ray studies in all cases showing chronic infection of the upper urinary tract. This is just as important in the infant or young child as in the adult. It is not infrequent that we see in young children partial or complete damage to one or both kidneys as the result of partial obstruction with secondary infection. These conditions, if recognized early, could be corrected without the loss of a kidney. The effects of partial obstruction in the urinary tract are very well brought out in that part of Dr. Randall's talk on pyelitis or pyelonephritis of pregnancy. Here we see a very excellent example of recovery both in infection and hydronephrosis after the cause of the obstruction has been removed. We feel that in cases of pyelitis of pregnancy the most important thing is adequate drainage over a period of several days or a week. In this way we are able in many cases to allow the patient to go to term and at the same time control the renal infection.

I think the hardest thing we have to treat as urologists is a chronic infection of one or both kidneys with or without dilatation, but generally accompanied by a certain degree of dilatation of the intrarenal portion of the kidney pelvis. In some instances we are unable to determine the exact cause, as there is no visible obstruction at the time of the examination, but we take it that the renal dilatation has been secondary to infection. Of course there is always a possibility that the mechanical obstruction has been removed prior to our examination, as for example a woman who has borne several children, with an acute exacerbation of renal infection accompanying each pregnancy.

The result obtained in the treatment of these cases by ureteral catheterization and renal drainage is often only temporary; by that I mean relief probably of vesical irritability, if present, with improvement in the general health of the individual. But the kidney infection persists and treatments are often repeated many times with no permanent cure effected.

I have often thought probably Von Lichtenberg was correct in his practice of performing a nephrostomy in these chronic cases.

We have been using recently in chronic colon bacillus infections of the kidney, the ketogenic diet as prescribed by the Mayo Clinic. All patients under this régime have shown improvement during the two months that they have been treated. Many of them had been treated over quite a period of time by the usual methods of ureteral drainage, etc., without much gain.

ENDOSCOPIC REVISION OF VESICAL NECK OBSTRUCTIONS— ITS PLACE IN THE SURGERY OF THE PROSTATE

By JOSEPH FRANCIS MCCARTHY, M.D., New York City,

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In brief, the underlying principles of this method are based on an unique system of lenses, the product of the fertile brain of Mr. Frederick Wappler, son of the distinguished Mr. Reinhold Wappler, of New York. The telescope and lamp are incorporated in a single tube of 11 F. diameter. The sheath is likewise a straight tube without beak or curve, and the opening at the terminal is oblique. The vision is of the amphitheatre type and may be compared to that of the judge of a tennis match. Seated upon a high platform, he sees straight ahead or obliquely downward, as the case may be. Except for the space occupied in the sheath by the telescope, the tube is free for the passage of straight rigid instruments, operating, catheterizing, etc., the vesical terminals of which may be visualized with practically the same clarity and precision as was heretofore had with the indirect telescope. The advantages claimed for this instrument and subsequently proven are, that one may use the larger occlusive type of ureteral catheter or large rigid operating instruments, electrodes, etc., and finally, that in a single sitting, one may visually explore the bladder, prostatic and anterior urethra with a facility of manipulation and degree of precision hitherto unattainable. Thorough familiarity with this instrument is an essential pre-requisite to the successful employment of the visualized electro-tome for endoscopic revision of prostatic obstruction.

Some eighteen years ago, shortly following the advent of the Oudin current in the treatment of bladder tumors, I published an article concerning the use of this mono-polar current for the correction of prostatic fibrosis and early middle lobe obstruction, and reported therein, two spectacularly successful results. My later efforts were sufficiently discouraging, however, to warrant the discontinuance of this

method. It seemed to me at that time that the collateral sciences of optics and electricity were not equal to the exacting demands of so highly technical a procedure.

As in every real achievement, the present advances in this fascinating field are, through the process of trial and error, the filtrate as it were, of the cumulative efforts of many investigators here and abroad. Much of the credit, however, for our progress in diagnostic urology, must as a matter of simple justice, be laid at the door of the Wapplers, who are scientists by predilection and business men by circumstances. It was not until the development of the Pan-endoscope previously described, and the elaboration of the large radio-tube type of cutting current that these collateral sciences had at last approximated our own and our predecessors long held clinical concepts. Did I fail to admonish my auditors of the difficulties and the dangers inherent in the method, I would be returning evil for good. Essentially, the work is highly individualistic. A large number of my colleagues consider it one of the outstanding surgical advances of this generation. Others of equal or greater eminence would cheerfully cast it to the four winds. It is seductive alike to patient and operator. It has brought much grief and much more comfort and peace of mind. Employed by those whose knowledge of urology has been inducted largely through the point of a scalpel, it is about as innocuous as a sub-machine gun in the hands of a healthy boy who has just finished reading "Deadwood Dick". Whereas, with those sympathetic with and skilled in the use of fine instruments and who are surgically competent, it has proven a benefaction.

Equipment. This consists of what is called the McCarthy visualized electro-tome and a radio-tube type of cutting apparatus also bearing the author's name. The lens system em-

ployed is that of the previously mentioned pan-endoscope. To this is adjusted a wire loop with a rack and pinion attachment which permits easy forward and backward movement of the loop. The loop when charged with this current cuts through the densest prostatic tissue as though it were so much plastic material. With a fore-knowledge of the nature of the obstruction, the tissue is removed seriatim, by placing the loop behind the obstruction and drawing it slowly and steadily through it until the former has reëntered the sheath. The arc of the current, which may be compared to the radio current, cuts and coagulates the tissue. At the completion of the operation, a well defined tunnel should result, with no evidence of encroaching prostate anywhere along its trajectory, which extends in gradually enlarging diameters from immediately posterior to the verumontanum to the internal sphincter. Severed pieces should be removed during or before the conclusion of the operation, and bleeding points coagulated by means of special electrodes designed for this purpose. Following this, a catheter of large size is left indwelling for at least 48 hours, after the urine has remained macroscopically clear. Recently, we have employed with complete success, a suction apparatus similar to that used for the evacuation of stone fragments, supplemented with a metallic attachment, adapted to the endoscopic sheath. It has been our custom lately, following the removal of the obstructing prostate, to coagulate only the active bleeders, and subsequently by means of a compression catheter bag, for about ten minutes to control the venous ooze.

Case Selection. The following quotations from a previous communication read before the American Urological Association at Toronto adequately states the present position of the writer on this question: "Primarily, it should be understood that in the development and proper allocation of so decided a departure, it is wise to underestimate its advantages and to restrict its application within such narrowed confines as will serve the dual purpose of comforting its exponents and confounding captious criticism. It is to be feared that the spectacular immediate results obtained and the enthusiasm engendered thereby have caused

some of the advocates of this method, including the writer, to lose sight of this precaution. Every communication spoken or written by us on this subject has emphasized the highly technical nature of the method, that its use should be limited to Urologists qualified in the application of endo-urethral instrumental methods and whose clinical and surgical training has been such as to permit of judicious discrimination in case selection as well as the ability to make prompt decision in the occasional complication that sooner or later must inevitably occur. He should also be able promptly to carry out any form of necessary intervention. Moreover, the fact should be emphasized that anyone even with these qualifications, who believes he can carry on with so precise a procedure as is endo-urethral revision, without a fore-knowledge of its technical difficulties, personal observations and contacts with the pioneers in this field, is headed for disillusionment. Finally, until time and experience have thoroughly familiarized him with the technic and its limitations, his efforts should be confined to the simplest type of cases. Though the writer has carried out this operation with gratifying results in practically all forms and types of prostatic hypertrophies save the rare enormous enlargements, and has done but a few prostatectomies during the past year and a half, it is the present consensus of opinion in our department at the New York Post-Graduate Hospital, that this procedure should be limited to the correction of prostatic fibrosis, so-called collar condition, small and moderate middle lobes, and moderate-sized combined middle and lateral lobes.

Borderline Cases. Prostatics, even those included in the above category, who bleed readily on instrumental examination or who manifest pronounced temperature excursions following such inspection, should be evaluated with scrutinizing care. Many such cases do better with a preliminary cystotomy and a later determination as to revision or prostatectomy.

Case Types Contra-indicating Revision. The enormous, the succulent or spongy prostate, the frankly engorged readily bleeding type, and such forms of encroachment as from their angular conformation or infiltrative nature, inhibit instrumental manipulation, should be re-

served for primary cystotomy and later revision or prostatectomy.

Superannuated, Debilitated or Toxaemic Cases. How shall we proceed with this class? It has been contended by others that with preliminary catheter decompression, a considerable number of patients may be successfully carried through by partial or serial revision. While admitting this contention, the writer does not subscribe to or endorse it. Inasmuch as a buttonhole or cystotomy opening in the bladder carried out under field block anesthesia is accompanied by relatively little shock and does so favorably influence the clinical picture, it would seem the patient's welfare is best conserved by pursuing this course. The above classification is intended for general application. Individual adaptability and continuing experience will, of course, be the final arbiter."

The question naturally arises, if it becomes advisable to drain a patient's bladder, why not complete the job and take the prostate out? This query may be answered as follows: First, many two-stage cases have heretofore been drained for prolonged periods before the final enucleation was effected. With revision, however, it has not been found necessary to wait much longer than for the establishment of a definite fistulous tract. Secondly, in some of these two-stage cases, the second stage operation is not unattended with considerable risk. Finally, while patients seem willing to part with appendix or tonsils, most of those encountered by us seem disinclined to part with that object of their retrospective ruminations, the prostate. This experience is especially pertinent to medical men coming under our care.

Statistical. In approximately 200 prostatic revisions done in our service at the New York Post-Graduate Hospital, there were two deaths. One, a repeat case, died several months after his primary revision. On autopsy this case revealed a cystitis and a previously undisclosed bilateral calculous pyelonephritis which failed to cast a shadow on x-ray exposure. The other occurred two weeks post-operative from bilateral pyelonephritis.

Hospitalization. The average time in the hospital in the true hypertrophies was 9.72 days. In the vesical neck fibrosis, 9.28 days.

In the cases of prostatic carcinoma, 22 days. In prostatic hypertrophy with other complications of the genito-urinary tract, 37.92 days. A haemostatic bag was used secondarily in six cases. In one of these cases there was a slight post-operative dribbling. The ages varied from 49-89 years; six of them being between 80-89. Preliminary cystotomy was done in about ten of these cases for good and sufficient reasons. The foregoing cases were not selected; none were rejected who presented themselves for operation.

Post-operative Convalescence. It should be understood that urethral convalescence frequently is a matter of a number of weeks following the patient's departure from the hospital. Considering the nature of the operation, this is quite understandable. Micturitional frequency and occasional mild dysuria is not uncommon. Such symptoms, however, disappear coincidental with the healing of the operative field.

Post-operative Complications. Attention has been called to the possibility of pyelitis or even of pyelonephritis by a number of observers. In our department at the New York Post-Graduate Hospital, we have had two such experiences; the case previously mentioned of calcareous pyelonephritis. Incontinence has also been noted by a few authors. We, too, have seen two or three cases of temporary dribbling. These cases, however, recovered complete function of the sphincter. As yet I have found no satisfactory reason why there should be such an eventuality; it is a most interesting phase of this subject.

Symptomatic Results. These are dependent entirely upon the completeness of the job. When the operation is carried out as described elsewhere in this paper, the symptomatic results are spectacular and the patient quite willing to exhibit his prowess to his intimates. Where, however, the operator has for whatever reason failed in complete canalization of the prostatic urethra (and your writer has done this more than once in his earlier cases), urethral convalescence is much more prolonged and is notable for frequency of micturition and pyuria for a number of weeks, which however, eventually subsides. One revision should suffice. Repetition of the operation implies in-

complete canalization of the prostatic urethra. Repeat operations should never be performed until complete urethral convalescence has been established. Such convalescence should be determined by endoscopic inspection.

Controversial. During the past two years since the first publication by me on this procedure, over one thousand of the Visualized Electrotomes are now in use throughout the English and Latin-speaking world. It has met with general accord. From the standpoint of conception, design, construction and rationale, it is a logical and effective apparatus. The high point of controversy has focussed on the coagulating power of the instrument previously mentioned. Personally, I have consistently held the belief that the Spark Gap current is unsuited for this delicate work because of its inferiority as a tissue cutting medium as compared to the tube type of current. Secondly, that while some hold the view that the Spark Gap machine is more effective in the arrest of incidental bleeding (a most important feature), because of difficulty of current control and by reason of its tendency to carbonize not only the bleeding vessel, but the surrounding tissue as well, it should and probably does predispose to secondary hemorrhage, late infection, and possible fibrous tissue replacement. The use of the Spark Gap current for this operation has seemed to me comparable to watering an apartment house flower pot with a fire-hose. With the tube type of power, however, and the special coagulating electrodes, at least in my hands, the operation is carried out with the same precision and exactitude as accompanies open surgery. The vessels are sealed as though they were individually picked up with an artery clamp, and by reason of fine current gradation and accurate electrical calculation, according to the surface area of electrode, the surrounding tissue is spared unnecessary damage.

Nevertheless, my readers should know that we are still divided into three camps; those who use the cutting power herein advocated, those who employ the spark gap exclusively, and those who have tried the method only to cast it aside. In so radical a departure, however, such experience is to be expected. It is a significant fact that among the commercial

exhibits at a recent national surgical convention, the tube type of power predominated.

The preceding seems to me a fair exposition of the present status of this innovation in surgery, in America. It is also of the utmost importance to stress the unfortunate results that have eventuated from the too hasty application of this operation by those not too well qualified and its unwise over-extension by many who are or should be capable. It has been a common experience to hear the report from many of my friends that "one of my first two or three cases died, but now that I am familiar with the technic, my results are gratifying." All this is avoidable and these unpleasant details are herewith submitted that my colleagues shall profit by such experience. In the retrospect, it would appear that *our* good fortune resulted from the fact that for a long time we limited our attack to the earliest forms of prostatic encroachment and the comparatively bloodless fibroses, that we promptly intervened should the drainage be interrupted, that when necessary a pan-endoscope was introduced and the bleeding point coagulated, and, that finally, we promptly cystotomized and on two occasions, prostatectomized such as did not immediately respond to the milder measures. It has always been our conviction that procrastination is a poor haemostatic. It is also to be admitted that in a small percentage of cases, notably those with high blood pressure, the bleeding incidental to operation is, regardless of the method employed, difficult to control.

CONCLUSIONS

The dangers and disadvantages have been emphasized that my auditors may profit by our mistakes, our at-times misguided enthusiasm, and for the additional reason that because of its intrinsic merit, it is inevitable that in your experience, as has already been mine, it will in the preponderating number of prostatic obstructions, supersede the present methods of more radical surgical intervention, and much more important, it opens wide the door through which may be observed the vista of a much more complacent, a happier existence for the future senescent, because of the now possible prophylaxis of prostatism.

DISCUSSION

Dr. Markowitz, Jersey City: We have had about two years' experience with prostatic revision and have gone through the stage of apprenticeship that Dr. McCarthy speaks about. We have had our sad experiences, and I think we have learned more by the mistakes we have made than by our successes.

In our first ten cases we had two deaths, and both those deaths we attributed to hemorrhage. Our experience there taught us we were depending too much upon Nature, figuring we checked the hemorrhage sufficiently, and both of those patients passed out.

Dr. Herman, Philadelphia: Dr. McCarthy's proposal to use a small hemostatic bag after revision reminds me of a suprapubic prostatectomy in which a Hagner bag had been employed. This instrument as you know is removed ordinarily via the suprapubic wound. When questioned about the operation the patient remarked the considerable pain experienced when the interne pulled the bag through the urethra.

However great one's experience with other methods may have been, revision carried its own particular difficulties and dangers which were likely to increase proportion to the size of the obstructive mass. For this reason we have advanced cautiously in the application of the technic to large tumors. Since 1931 we have had one hundred and forty cases of prostatic enlargement in our clinic of the type that in the past would have been prostatectomized. Of these eighty have been subjected to revision. As time goes on, we have perfected the technic, and gained greater mechanical aptitude and now find

ourselves resecting a larger proportion of cases, possibly 65 per cent of the total at present.

Among our 80 resection cases there have been three fatalities, all of the latter occurring in exceedingly bad risks. One of these, an aged man, died of pyoarthrosis and empyema of the gall-bladder 16 days after operation; the second fatality, a very aged individual who had had suprapubic drainage for a period of three months prior to resection, died of cerebral hemorrhage following the operation. The third case was one of complete retention complicated by vesical calculi and alcoholism. Preliminary cystolithotomy was followed by delirium tremens from which the patient recovered but died of pneumonia 5 days after resection. Two of these cases had very large tumors and the resections were time-consuming affairs. I believe that we might have saved one, or, possibly, both of these patients had enucleation been done.

We have followed the 75 living cases with great care and they are all mechanically well; 13 complain more or less of burning on urination. Like Dr. McCarthy we have selected our cases with care although we are apparently resecting larger tumors than he advocates. We do not think the operation applicable to very large prostatic tumors.

Dr. Joseph F. McCarthy, New York City, closing: The mission I bring and what I am trying to promulgate is, that the medical profession must realize the fact that prostatism should be recognized early, that they should not delay, but insist that the obstruction be corrected at this time. Heretofore, neither the doctor, the patient, nor the specialist was willing to intervene early. I believe future generations need not anticipate prostatism if the profession is alive to its obligation.

PATHOGENY OF THE SEQUELAE OF CHOLECYSTECTOMY

By JOHN VICTOR DONNET, M.D., New York City

Department of Pathology, West Side Hospital, New York City, October 10, 1933

The first observation on record on the sequelae of cholecystectomy was made in 1650 by Zambecarri, who sectioned between two ligatures, the cystic duct of a dog without removing the gall-bladder and subsequently noted that the cystic duct became dilated. Zambecarri had not performed a true surgical cholecystectomy but as we will see later on, the suppression of the physiological function of the gall-bladder creates sequelae which are similar to the ones found after experimental cholecystectomy. Henceforth, many cholecys-

tectomies were performed on animals, however, not to study the sequelae of cholecystectomy but to ascertain the origin of bile and to establish the physiology of the gall-bladder. The systematic study of the physiopathogeny of cholecystectomy began with the writings of Oddi in 1888. Oddi removed the gall-bladder of three dogs, placed them under observation and then sacrificed them on the first, second and third post-operative months. He noticed during the first post-operative weeks that their stools were liquid and offensive and that their urines were highly pigmented, though there was no loss of appetite or weight. At the autopsy, he found marked dilation of the

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biliary tract, the degree of dilation being apparently proportional to the time elapsed between the operation and the autopsy. The findings of Oddi, stimulated much attention and mark the onset of a long series of experiments, chiefly, by Rosenberg in 1893, Masse in 1894, De Vogt in 1898, Hautefort in 1900, Haver and Clairmont in 1904, Henger in 1912, Judd and Mann in 1917, Dahl-Iverson in 1924, Coffee in 1926, Balice in 1927, Canavero in 1928, Rose in 1930, Bernard and Mallet-Guy in 1932.

In a general way, they all agreed with Oddi that the dilatation of the remaining biliary ducts follows as a rule a simple cholecystectomy. Rosendahl, however, considered this phenomenon purely accidental and of no physiological significance, while others, regarded this dilatation as an attempt by nature to reestablish a normal physiology in a biliary system which has been deprived of its pressure regulating cap.

Canavero in 1928, in a noteworthy contribution carefully analyzed and checked by experimentation on cholecystectomized dogs, the results of the previous workers. He found in the first series of autopsies, performed within two weeks after cholecystectomy, no apparent changes in the biliary ducts or cystic stump. In the second series, thirty to thirty-five days following cholecystectomy, all the animals presented a mild dilatation of the extra-hepatic ducts and of the cystic stump. In the third series, in which the animals were sacrificed between the third and fifteenth month, the extra-biliary ducts were markedly dilated and this dilatation extended in many instances to the intra-hepatic ducts. In an endeavor to explain the mechanism that brings about this dilatation, Naunyn determined the average pressure in the common duct and found it to be equal to about 25 millimeters of mercury, while after cholecystectomy, this pressure reached 50 to 55 millimeters. This increased pressure in the biliary tract was attributed to the spasticity of the sphincter of Oddi. Bile being secreted by the liver and not being able to flow into the intestines accumulates in the biliary tract, the pressure increases, the walls of the biliary ducts resist for a short period of time and then become dilated. The intra-

hepatic ducts reinforced by the hepatic tissue resist for a longer period of time but finally undergo the same transformation. Now we understand why the biliary tract deprived of its elastic reservoir becomes distended. It is interesting to note that a gall-bladder which normally contains from 30 to 40 cc. will double its volume under moderate pressure and that its capacity will easily reach 200 cc. without determining any rupture. Little is known as yet as to the determining factor causing the hypertonicity of the muscle of Oddi. Some believe that the surgical shock is responsible for it. This is very doubtful for we do not find it in other abdominal operations which are just as shocking as cholecystectomy. Kiss thinks that the lesion done to the sympathetic nervous plexus of the gall-bladder, branch of the coeliac trunk is the causative factor responsible for the spasticity of the muscle of Oddi.

It is surprising that the post-operative dilatation of the intra-hepatic biliary ducts and the high intra-biliary pressure do not create some pathological changes in the hepatic tissue itself. At any rate, histological examination of the liver tissue fails to show any great deviation from the normal. From the clinical point of view, nothing seems to point to a lesion of the hepatic cell. The urines remain negative and the icterus index is within normal during the post-operative period.

The changes undergone in the cystic stump are such that they merit special attention. Here the dilatation often reaches the size, and even simulates the morphology of a real gall-bladder. In 1904, Haberer and Clairmont concluded from their experimental work that after a simple cholecystectomy, the cystic stump was transformed into a new gall-bladder, which required about six weeks to develop. They also pointed out that such a diverticulum was not found when the entire cystic duct had been removed. These findings were confirmed by Eisendrath and Dunlavy in 1914. The hypothesis of the transformation of the cystic stump into a new gall-bladder was generally accepted until 1921 when Malzel pointed out that the so-called "neo-gall-bladder" was only a pseudo gall-bladder and attributed the formation of this diverticulum to a passive dila-

tation of the cystic stump. The walls of the cystic stump, weakened by surgical trauma and post-operative reaction, and partially deprived of its blood supply may undergo a far greater dilatation than the other portions of the bile ducts.

Are we dealing here with a true regeneration of gall-bladder tissue? Speaking of regeneration, one must take into consideration not only the morphology of an organ but also and mainly its histology and physiology. From the viewpoint of morphology, the neo-diverticulum, indeed, simulates a gall-bladder, but no physiological evidence has been obtained to substantiate this theory. In 1924, Dahl-Iversen confirmed the opinion of Malzel and showed that histologically, the so-called new gall-bladder was nothing more than a diverticulum which had undergone a cystic transformation. Canavero in 1928, from experimental work on dogs arrived at the same conclusion.

In 1930, Sutton confirmed the work of Canavero and chiefly studied the histological aspect of the biliary tract following cholecystectomy. Fifteen days following cholecystectomy, no macroscopical changes are apparent, although microscopically important modifications are already present. Sections through the cystic scare show an overgrowth of connective tissue, with formation of a small villi. The mucous membrane is eroded. The remnants of the covering epithelium consist of cylindrical cells with small nuclei and a cytoplasm containing fine granules, mainly at the periphery. The submucosa consists of fibroblasts, supporting groups of glandular elements. There is no demarcation between the submucosa and the fibro-muscular coat. Section of the extra-hepatic duct virtually shows the same changes, while section from the intra-hepatic ducts, as well as of the liver tissue, shows no deviation from the normal. During the second and third months following cholecystectomy, there is a marked dilatation of the extra-hepatic ducts. Microscopical sections of the latter reveal marked changes in the mucosa, which is uneven, with an almost entirely destroyed epithelium. Here and there, small islands of a flat epithelium are seen. The submucosa presents nothing worthy of note. The elastic lamella

and fibrilla are ruptured and resemble to a certain extent the changes found in small arteries in cases of hypertension. These changes are particularly evident on sections obtained from the cysto-hepatic region. The section made from the walls of the "pseudo-gall-bladder" show exactly the same changes. The section made from material obtained closer to the liver itself shows very little modification. The mucosa presents numerous folds, but it is not eroded and consists of cylindrical cells arranged in one layer formation. Sections made through the hepatic duct show no deviation from the normal. Sections made from material obtained six to fifteen months after cholecystectomy fail to reveal the presence of a mucosa. The degenerative process is found throughout the entire extra hepatic tract. The choledochus consists of a dilated tube, the wall of which is mainly fibrotic. This process gradually extends to the intra-hepatic ducts, which are dilated and surrounded by hyperplastic connective tissue. The main feature is a gradual dilatation with increased connective tissue, fragmentation of the elastic lamella and disappearance of the mucous membrane.

Excretion of Bile following Cholecystectomy: The question as to whether bile is altered in its various physiological aspects after cholecystectomy has been the subject of much discussion. It has already been noted that cholecystectomy increases the tonus of the muscles of Oddi to the point of spasticity. It is important to bear in mind that the muscles of the sphincter of Oddi varies greatly with the individuals. It consists at times of a few muscle fibers only and in other instances it is a strong muscle. It is, therefore, important to take into consideration such variations before a definite conclusion can be reached as to its dysfunction following cholecystectomy. Rosenberg in 1893 and Hengel in 1912, finding the intestinal tracts of their cholecystectomized animals filled with bile even after a fifty-hour fast, concluded that the flow of bile was continuous. Delore and Cotte, impressed by the absence of digestive disturbances after cholecystectomy, maintained that the biliary system readjusted itself after cholecystectomy and that its physiology was not disturbed by this operation. Rost, experimenting on dogs

by means of a duodenal fistula, found several months after cholecystectomy that the flow of bile was at times continuous, and at other times intermittent, although with shorter intervals between each outflow. Klee and Klupfelf arrived at the same conclusion. The experimental work of Judd, Mann, Eisendrath and Dunlavy, show that the pressure of bile is increased after cholecystectomy, and then gradually decreases to zero, six weeks after operation, and attributed this phenomenon to the dysfunction of the sphincter of Oddi after cholecystectomy. McMaster and Jacobson found in cases of congenital absence of the gall-bladder, as in cases of post-cholecystectomy, a marked diminution in the tonus of the sphincter of Olli. In 1921, Specht reported a normal outflow of bile in fasting animals six months after cholecystectomy and that this outflow could be induced by an injection of 20 cc. of a 5 per cent solution of peptone. The outflow was intermittent, the bile was dark and the phenomenon appeared two minutes after the injection. This test repeated two hours after the first injection brought about the same reaction. Following two injections of a solution of peptone, one after the other, it was noted that the second injection remained without results. He further found that after a meal the excretion of bile was apparently normal. The findings of Dahl-Iverson in 1924 do not support Specht's data, but are in accordance with Rost's theory. The work was carried out on rabbits, dogs and monkeys. Some of these animals were bile continent while others presented a constant outflow of bile and still others were semi-continent. He pointed out that the degree of continence does not correspond to definite types of dilatation of the biliary ducts, but seems to depend upon the ratio of the volume of biliary tract and the amount of bile per hour, time playing apparently no rôle. In a study of the duodenal contents of cholecystectomized human subjects, which we carried, two to five months after operation, we confirmed Dahl-Iverson's findings in their cholecystectomized animals. Some had an intermittent flow responding to either peptone or magnesium sulphate solutions, while others had a more or less constant flow of bile, the latter apparently not being in-

fluenced by solutions of peptone or magnesium sulphate.

The antiseptic properties of bile, judging from what one may gather in the literature, is a question that has aroused more discussion based on proposed theories than on scientific experimentation *pe rse*. In vitro, the properties of bile upon certain micro-organisms are well established. Virulent pneumococci are rapidly killed and dissolved by bile. A solution of one to two hundred, or even one to three hundred of rabbit, human or beef bile converts a 12 hour pneumococcus broth culture into a clear transparent fluid from which no pneumococci, either by microscopical examination or by culture can be recovered. This phenomenon does not occur if the young culture has been killed by heat or allowed to grow old at room temperature or in the incubator.

Bile has no action on streptococci and little action on meningococci. Protozoan of various types are also dissolved by bile.

This bacteriolytic property of bile is due to bile salts. Glycocholate, taurocholate or sodium and the salts of higher unsaturated fatty acids exhibit this solvent action while glycochol and taurin do not.

Bile salts, especially the taurocholate and glycocholate of sodium, have a definite reënforcing action upon the agglutination of bacteria. Therefore, if bile has the property of agglutinating and dissolving certain strains of micro-organisms, it also has the property of exciting, in a dilution of one-half to one-third of one per cent with peptone, the growth of bacilli belonging to the typho-colon group.

Having pointed out that bile has a definite effect on micro-organisms (bacteriological properties) in vitro, we shall now consider the action of bile in vivo. The amputation of a septic gall-bladder has apparently very little influence upon the sterilization of the duodenum and biliary tract. Investigation of the duodenal contents in human subjects following cholecystectomy invariably shows the presence of pathogenic micro-organisms. Antoine, Berard and Mallegny have repeatedly isolated colon bacilli from the duodenum of cholecystectomized human subjects. Streptococcus viridans, Streptococcus hemolyticus, Straphylococcus aureus, Colon bacillus, Communis

and Communor, were isolated by us in similar instances, while these micro-organisms failed to develop upon cultures obtained from the throat, esophagus and stomach in the same human subject. A study of the flora of the biliary tract made by Gilbert and Littman showed that aerobic micro-organisms, as a rule, were present in the middle third of the choledochus, while in the inferior third, down to the ampulla of Vater the flora was of the aero and anaerobic type, the intra-hepatic ducts remaining constantly sterile. Others (Luciani) believe that the increased intestinal putrefaction in biliary retention could be attributed to the absence of biliary acids in the intestinal tract, the latter being a peristaltic stimulant, and concludes that putrefaction is due more to the stagnation of feces in the colon than to increased virulence of the flora.

The virulence of definite strains of colon bacilli isolated from the gastro-intestinal tract of rabbits and dogs after cholecystectomy was studied by Balice. His work was carried on with such precision that accuracy of the result need hardly be questioned. He showed that 4 Mgm. of colon bacilli isolated from a normal rabbit, before cholecystectomy, suffice to kill a healthy 320 Gram guinea pig, while $1\frac{1}{4}$ Mgm. of the same micro-organism obtained from the same rabbit, after cholecystectomy, were sufficient to kill a guinea pig of equal weight. From our experimentation, we find that the lethal dose per pound of guinea pig of colon bacilli obtained from a non-cholecystectomized rabbit is equal to about 250,000 bacilli. This lethal dose drops to about 75,000 after cholecystectomy, the cultures of course, being obtained from the same rabbit before and after cholecystectomy. The influence of surgical shock or trauma was found to have no bearing on the virulence, as several months after cholecystectomy, when the animal had regained its weight and all evidence of shock and trauma had disappeared, the strains of colon bacilli isolated from its feces retained their high virulence.

Various theories have been advanced to explain the mechanism responsible for this increase in virulence of the intestinal flora following cholecystectomy. It has been said that the lowered concentration of bile (being low-

ered eight times), might have some effect. If this is the case, we cannot agree with Gilbert and Littman who have shown that the intra-hepatic ducts constantly remain sterile, while the concentration of the bile in these ducts does not vary from the bile found in the duodenum of a cholecystectomized animal. The increased virulence of the intestinal flora is apparently independent of the continence of incontinence of the sphincter of Oddi and of the dilatation of the biliary ducts or of the cystic stump.

Effect of Cholecystectomy on the Gastro-intestinal Tract: Until 1924, it was generally accepted that cholecystectomy had no influence upon the gastric or pancreatic secretions. This belief was based on the clinical fact that a large number of cholecystectomized patients remain free from gastro-intestinal disturbances. Dahl-Iverson undertook the verification of this statement by experimental work on dogs and monkeys and found that the amount of hydrochloric acid was not modified after a cholecystectomy while pepsin, on the contrary, was decidedly increased from the second post-operative day on. This increase being two or three times the normal amount. The volume of the gastric content does not seem to be affected, thus pointing to normal gastric evacuation after a cholecystectomy.

As far as the pancreatic functions are concerned, Agrifoglio in 1928, found in his long series of experiments that the amount of un-assimilated fat and un-assimilated nitrogen was about twice the normal amount. In other words, the pancreatic function is decidedly disturbed. The marked increase of pepsin after cholecystectomy may be considered as a hyperactivity of the gastric function to compensate a deficient pancreas.

Resumé: The study of the sequellae of cholecystectomy when based upon purely experimental findings shows that the amputation of the gall-bladder determines definite physio-pathologic disturbances:

- (1) After a period of about thirty days, the extra-biliary tract is dilated. This dilatation is progressive and reaches ultimately the intra-hepatic ducts.

- (2) At times the ectasia of the cystic

stump is such that it resembles a gall-bladder of neo-formation.

(3) Histological studies show that we are not dealing with a regenerated gall-bladder.

(4) To the dilatation of biliary tract corresponds a progressive destruction of the epithelium with fibrous transformation of the walls and degeneration of the elastic tissue.

(5) The biliary tract becomes infected; and the virulence of the intestinal flora is excited.

(6) The rhythm of the excretion of bile is markedly disturbed.

(7) The digestive functions are modified mainly as far as the assimilation of fats are concerned.

(8) When the physiological function of the gall-bladder has stopped, pathological changes similar to post-cholecystectomy sequelae appear.

(9) The idea that a cholecystectomy does not create important perturbations is not well founded.

(10) Practical conclusion: A cholecystectomy is justified only when the function of the gall-bladder is profoundly altered.

CONGENITAL HYPERTROPHIC PYLORIC STENOSIS IN INFANCY

With a Report of 30 Cases Operated on at the Cooper Hospital,
Camden, New Jersey

By E. G. HUMMEL, M.D., Camden, N. J.

Among the twenty or more listed causes of vomiting in infancy, pyloric stenosis, although one of the rarer causes, is sufficiently frequent to warrant its consideration as a possible cause in any case of vomiting during the first few weeks of life.

In dealing with pyloric stenosis our first thought is to differentiate true stenosis from a closely allied condition, namely, pylorospasm, in which there may be merely a tendency to spasm of the pyloric sphincter. In stenosis, however, there is not only spasm but a definite hypertrophy of the circular muscular fibers of the pylorus and a fibrosis with constant and practically complete occlusion of the pyloric orifice.

Opinions differ as to how much of the vomiting is due to spasm and how much is due to the tumor. It is the opinion of many that there is some gastric and pyloric muscular spasm in every clinical case of pyloric stenosis. Other writers attribute the disorder to imbalance of the involuntary nervous system. Others think that the symptoms in pyloric stenosis might occur as the result of suprarenal impairment. Still others believe that resultant

vegetative imbalance could produce various degrees of pylorospasm and hyperperistalsis. Whatever the etiology, however, pylorospasm and stenosis may be interrelated. Clinically, there are two distinct types, a pylorospasm without a true obstruction, and a true hypertrophic pyloric stenosis with an associated spasm produced by the tumor. Laboratory findings teach us there is no pathology associated with the tumor—simply muscle hypertrophy.

It is not necessary to discuss at any length the symptoms associated with this condition before this gathering as they are all very familiar to you, namely: projectile vomiting, rapid loss in weight, scanty stools, dehydration, malnutrition, tumor, and reverse peristalsis. I should like to emphasize some of the points of interest that have been valuable to me in my experience with a series of thirty cases operated on at the Cooper Hospital.

It would assist very much in our diagnosis if we were always able to feel the pyloric tumor. The fact that the pylorus is located under the liver often makes it difficult to find. Therefore, it has been my experience to be able to palpate the tumor in only about 50 per cent of the cases. It is not essential for the

diagnosis that a tumor should be palpated, with all the other clear-cut symptoms that go with stenosis. In these thirty cases diagnosed as stenosis, which came to operation, there was found a marked tumor on opening the abdomen in every case with decided obstruction. These cases, giving the usual symptoms of stenosis, were tested with atropine up to the point of tolerance. In each case this drug proved a great aid in differentiating the pylorospasm from the true stenosis.

It is the opinion of some clinicians that the application of the therapeutic roentgen and radium test for operative intervention is of value in cases that do not respond to internal therapy within forty-eight hours. Personally, I have had no experience with the x-ray test. Sufficiently large doses to effect pyloric tumor hypertrophy might in turn affect the muscle tone and glandular structures of the neighboring organs which are susceptible to irradiations, with resultant disadvantage to the patient.

Strauss and Hass are of the opinion that the Rammstedt operation, by severing the nerves through which the reflexes are induced, not only has the same effect as atropine, but also causes an atrophy of the tumor; while atropine paralyzes the nerve endings, the tumor remains the same.

Fluoroscopic examination after barium may be of service in differentiating between early pyloric stenosis and duodenal atresia, cardiospasm, and esophageal malformations; but the danger of increasing the obstruction with barium in stenosis must be considered.

The examination of bile stain vomitus would also aid in differentiating stenosis from duodenal atresia. The peristalsis from left to right should not be confused with the peristaltic waves in the transverse colon which pass in the opposite direction. And in those cases in which the stomach has become much dilated and ptosed, the waves may be seen passing downward to the right and may cease in the neighborhood of the umbilicus or below it.

In severe cases of pyloric stenosis in which the large portion of food taken is vomited, very little absorption of water takes place. Consequently, the urine is scanty and high-colored, and the infant becomes dehydrated, resulting

in a great loss of chlorides from the body in the form of hydrochloric acid and to a lesser extent, sodium chloride, with retention of the sodium. This depletion of chlorides may result in a severe degree of alkalosis and accompanying symptoms. Such a shift toward the alkaline side is just as serious as a similar shift to the *acid* side, or acidosis, if not more so. To raise the calcium content of the blood in the treatment of gastric tetany following stenosis the administration of acids or acid salts (hydrochloric acid, calcium chloride) with viosterol and ultra violet ray are valuable aids and relieve the acute symptoms in a few hours.

These conditions must be recognized early and corrected as soon as possible before handing the case over to the surgeon, who realizes infant surgery is more imperative in its demands for pre-operative preparation, careful handling of tissues, and the prevention of hemorrhage. Infants do not stand well the loss of blood and prolonged operations; they are very sensitive to shock. However essential and indispensable the operation, nevertheless, it is but one of the important factors in handling these cases. The results of operation, however, are very disappointing unless proper attention is given to the pre-operative and post-operative care of the patient.

The condition of the baby at the time of operation is certainly most important. In these patients showing poor nutrition, dehydration, anemia, abnormal distension of the stomach, and disturbance of the acid base equilibrium, operation can not be expected to accomplish the impossible. Most of these cases are brought to the hospital markedly dehydrated, and at times showing alkalosis. To overcome these conditions abundant subcutaneous injections of Ringer's solution are necessary. If athrepsia is present, glucose solutions or whole blood transfusions are indicated. Eighteen to twenty-four hours are given to replacing fluid loss and to counteracting starvation symptoms, before we feel safe to operate. Hence, the big part of the battle is fought before entering the operating room. The actual mortality a few years ago, with all cases considered, was probably 20 per cent or more. This high mortality, which is now preventable, was due chiefly to failure to recognize this condition early and

apply proper pre-operative and post-operative care with concentrated nursing. Dr. Donovan reports a mortality of but one per cent in his last hundred cases operated upon at the Babies' Hospital, New York City. Therefore, the whole problem of what to do with pyloric stenosis, after a diagnosis is established, is very simple, since surgery can give satisfactory and permanent results. With such a low mortality, we would be taking greater risks by delay through other methods of treatment.

Fredet-Rammstedt submucous pyloroplasty is the operation of choice. This properly belongs to the realm of the surgeon.

In considering the post-operative care, the surgeon inserts a tapered glass tube as the last stitch is about to be tied and through this introduces as much warm salt solution as the peritoneal cavity will hold. The tube is then removed and the last stitch tied.

On return from the operating room take the temperature every three hours for twenty-four hours, and place the baby in an incubator bed if necessary to keep normal body temperature.

Lower the head of the bed after operation until recovery from anesthetic to prevent aspiration of mucus; after which place the patient in semi-erect position until all food is retained.

On return from the operating room, give by enteroclysis:

1 oz.—5% Sol. sodium chloride

1 oz.—5% Sol. glucose

15 min.—spiritus frumenti

and repeat every six hours for first twenty-four hours.

Feed the baby with a medicine dropper, with a rubber tip on it, in routine order:

15 cc. distilled water, 2 hours after operation

4 cc. breast milk or albumin milk with

10 cc. distilled water, 4 hours after operation

8 cc. breast milk or albumin milk with

4 cc. distilled water, 6 hours after operation

The child should be taking 32 cc. of formula at the end of 48 hours, gradually increasing until caloric requirements are met, and not

allowing the child to nurse until it has gained sufficient strength. If unable to obtain breast milk, a high protein diet is used; a formula of albumin milk and dextri maltose is arranged to fill the caloric needs.

A SERIES OF 30 CASES OF CONGENITAL
HYPERTROPHIC PYLORIC STENOSIS OPER-
ATED ON AT THE COOPER HOSPITAL,
CAMDEN, N. J.

Name	Sex	Age in wks	Days in Hospital	Gain in ounces	Lost Birth wt.	Diet	Remarks
VW	F	5	13	8	x	CM	
RF	M	4	16	12		CM	
JR	M	8	9	4		CM	
WB	M	4	14	8		CM	*1
JS	M	4	10	12		Whey BM	
CC	M	6	11	14		CM	
NN	M	5	14	4		CM	
GS	M	5	5	Died	x	BM	*2
BR	F	4	20	28		BM	
HM	F	8	9	16		AM	
RB	M	4	14	32	x	AM	*3
WC	M	4	14	9	x	AM	
CN	M	5	16	11		BM	
CD	M	4	13	10	x	BM	
GC	M	7	22	22		AM	
VD	F	6	20	16		AM	
ER	M	4	4	Died	x	FAR	*4
KJ	M	4	16	33	x	AM	
WB	M	3	9	12		AM	
TD	M	8	15	26		AM	
WB	M	3	17	16	x	AM	*5
LC	M	5	18	18	x	AM	
EH	F	7	13	24	x	AM	*6
BB	F	4	12	18		AM	*7
JE	M	4	4	Died	x	AM	*8
RF	M	4	9	8		AM	
DH	M	6	17	8	x	AM	*9
CG	M	5	99	30	x	AM	*10
						BM	
CC	M	7	16	14		AM	
RS	M	6	11	2		AM	

*1 WB Operation for appendicitis in 1933, eleven years following stenosis operation.

*2 GS Started to gain; 5 days following op. sutures gave way; repair done; died of shock.

*3 RB 8 lb. at birth; 6 lb.-1 oz. at operation; 8 lb.-1 oz. 14 days afterwards. 2 lb. gain in 2 weeks.

*4 ER 9 lb. at birth; 5 lb.-12 oz. on entering hospital; tumor palpable; temp. 104°; convulsions, alkalosis, local anesthetic, collapse.

*5 WB Local anesthetic.

*6 EH 7 lb.-4 oz. at birth; 5 lb.-1 oz. at op. Gain 1 lb.-8 oz. in 13 days.

*7 BB Two children—First bad stenosis; second, pyloro-spasm.

*8 JE Tumor palpable. Spells of cyanosis. X-ray neg. for thymus. No attacks of cyanosis following op. Autopsy findings—broncho pneumonia.

*9 DH Acute nephritis following intraperitoneal salt sol.

*10 CG Gastric tetany, loss of HCl. Alkalosis, tetanic tremors, Cal. Gluconate, HCl, NH₄Cl, Calcium Chloride, Viosterol, Ultra Violet Ray.

Protein digestion during the period of infancy is very complete. Since protein contains nitrogen, which is essential in replacing the nitrogenous waste of the body, it should there-

fore form a very important part of the diet of an emaciated infant following stenosis. Our experiments with albumin milk in these cases have been very gratifying and the gains in weight have been extraordinary.

I present the following chart, which has been prepared from the hospital records of 30 cases, showing final results and giving a few interesting observations:

CONCLUSIONS

(1) Pre-operative preparation and post-operative care are the most important factors in lowering the mortality in pyloric stenosis.

(2) Concentrated nursing with a *skilled* nurse in these cases before and after operation is an important factor in lowering the mortality.

(3) Surgically, the Rammstedt operation is the method of choice.

(4) A high protein diet should form a very important part of the post-operative feeding of an emaciated infant following stenosis.

DISCUSSION

Dr. Edward J. Donovan, New York City: I believe it is absolutely necessary to feel the tumor, as it is pathognomic of this condition. The picture of pylorospasm may be precisely identical to that of pyloric stenosis except on palpation of the tumor. I have made it a rule not to operate until I have felt the tumor; and sometimes it is necessary to make several examinations before this is accomplished. The child must be perfectly relaxed, and, if possible, it is well to have the stomach empty when the examination is begun. We often pass a stomach tube and examine the child when the stomach is empty. I believe that we have operated on no case where we did not think, at least, that we had felt the tumor. In the first series I reported, there were three cases of mistaken diagnosis. At operation they did not have tumors, but that, I am sure, is a condition that can be very easily overcome by painstaking examination of the abdomen. Of course, it is possible to miss the tumor, but I am sure that if the conditions are right at the time of examination, it is possible to feel it in every case.

Two years ago in paper referred to by Dr. Hummel, I advised making pressure on the fundus of the stomach with one hand while palpating the tumor with the other. This will move the tumor more to the right and bring it down, making it more easily palpable. I do not use x-ray for diagnosis as I do not feel that it is necessary. The barium or bismuth used is difficult to get out of the stomach as it clings to the mucous membrane after the operation.

We have done the Rammstedt operation in all

cases and have found it very satisfactory. In Dr. Downes' and Dr. Bolling's report of between 700 and 800 cases, the results since 1912 have been excellent. This operation gives a permanent cure, as the pyloric tumor disappears, in contrast to those cases in which a gastroenterostomy was done and the pyloric tumor has been found unchanged years later.

Preoperative preparation is the most important factor in lowering the mortality. Regardless of what condition the baby is in, we take all the time we like to prepare him for operation, three or four days if necessary. We feel now that we can put the poorest kind of a surgical risk in condition to stand an operation in a very short time. When my series was begun we were operating upon these cases as emergencies, and, of course, the mortality in the early series was very high. This was because we did not appreciate the fact that the baby was not in a condition to stand any kind of an operation.

After operation, we give breast milk, if possible, for the first five days. The baby nurses twice on the sixth day, and so forth until he is completely breast fed and discharged on the tenth day. If he has to be put on a formula, we give evaporated milk. These babies have a very low food tolerance, and, I think, the feeding post-operative is very important. They are easily upset, and may have gastroenteritis unless they are carefully fed.

The mortality in the last 100 cases reported was one per cent; and I have done almost another hundred since that time and have lost none. We now feel, therefore, that we may almost assure the parents that we can bring the child through the operation safely.

As to colored patients, I have operated on two, one boy and one girl. Pyloric stenosis is seven times more common in male than in female children, and it is extremely rare in colored children.

I have been using a right rectus incision which is rather high. That is, in order to get at the pylorus, we have to lift the liver up. We have used this incision about 175 times and have had no incisions break open since beginning its use. It is very distressing to have these incisions break open as it is very difficult to sew them up again and, of course, it often complicates the post-operative recovery very decidedly. It is very nice to have an incision that you feel is not going to open because it is completely buffered by the liver.

Dr. Vincent Del Duca, Camden: I agree that feeling a tumor is not essential to the diagnosis; but I do believe that in the border-line cases it is of tremendous value.

In palpating the tumor, ordinarily the child is not sufficiently relaxed. It is then necessary to resort to an artifice to cause vomiting, such as giving enough sugared water. Immediately after vomiting, the child is thoroughly relaxed and palpation becomes easy.

The presence or absence of bile is important when eliciting the history, because there is another condition, even rarer than pyloric stenosis, that must be thought of, namely, duodenal stenosis; the pres-

ence of bile rules out pyloric stenosis and favors the presence of duodenal stenosis or some other cause, for the vomiting.

Dr. Hyman I. Goldstein, Camden: One of the most important facts presented by Dr. Hummel was the 100 per cent incidence in the chart of the white children; and that is not because the service which Dr. Hummel has is in a city where we are short of colored folk.

Dr. M. L. Ripps, Elizabeth: Leaving a closed catheter in the wound in order to administer fluid does not seem particularly necessary. If the child is in fairly good condition, he will not need much fluid other than that taken in the diet, and if he does, the water certainly can be administered by hypodermoclysis or even by intraperitoneal injection.

Dr. Ernest G. Hummel, Camden (closing): If there is any misunderstanding regarding the reference I made in my paper to the last hundred cases operated upon at the Babies Hospital, New York City, I wish to make it clear that it was Dr. Donovan's article in the *Annals of Surgery* I referred to, in which he reports a mortality of but one per cent in the last hundred cases he operated upon.

Regarding the discussion of food in these cases the question has arisen as to why one food would not give just as good results as the other after

operation. In answer to this I would say that these cases are treated as all cases of dehydration and emaciation, and children retain their water content much better on a high protein diet. Also, protein contains nitrogen which is essential in replacing the nitrogenous waste of the body; therefore, it is very important in emaciated infants, whether due to stenosis or other causes.

With reference to the comparison of pylorospasm and pyloric stenosis I am unable to give the number of pylorospasms that came under our care during this time, and the time of my paper would not permit me to discuss them in it, but I would say that all did well on diet with atropine. The exact calcium content in the case reported with gastric tetany I am unable to state at this time.

Regarding therapeutic roentgen and radium tests for operative intervention, would say that I heard the paper of Dr. Barbour at the Philadelphia meeting, which was discussed by Dr. Hess, who was very doubtful as to whether the roentgen-ray method of diagnosis should be used. After hearing several discuss the paper I talked with some x-ray men and their attitude was not in favor of using x-ray therapy because it took so much to affect normal muscle hypertrophy that they thought it would be dangerous to use sufficiently large doses to affect pyloric tumor hypertrophy. It might in turn affect the muscle tone and glandular structures of the neighboring organs which are susceptible to irradiations.

THE ETIOLOGY OF DYSLALIA

By I. J. WOLF, M.D., Paterson, N. J.

The opportunity to present a paper on dyslalia before this Society is evidence of a scepticism on the part of pediatricians that all children outgrow speech defects. The child in learning to talk passes through a period of faulty speech or lalling. This is physiologic. If the onset of speech is retarded or the period of lingual development prolonged beyond the third year, the condition is pathologic. The speech manifestations of both these periods, normal and abnormal, is known as *dyslalia*. In the former instance it is called *physiologic dyslalia*, in the latter, *pathologic dyslalia*.

Manifestations of Physiologic Dyslalia. In the normal infant the acquisition of speech begins shortly after birth. Crying is in reality a form of speech. Although it is reflex in nature at birth, it soon becomes influenced by

will and the infant is able to express his wants quite clearly. At least we know whether he is hungry, suffering pain, or just onerous. Soon afterwards, he spontaneously discovers many primitive sounds, such as gurgling, babbling, and crowing. As he grows older he is able to repeat sounds that he hears. This repetition is meaningless and is known as *echolalia*. Coincident with this period is the comprehension of speech. Its exact onset is difficult to discern. At first the infant learns to appreciate differences in tone quality. He starts at a harsh sound. He is soothed by a quiet one. Slowly he learns to recognize the more complex sounds comprising words. At about the age of one and a half years he acquires speech. By this is meant that he is able to associate the word he utters with what it means. If he calls his mother, he associates the word with her and does not repeat it without meaning. From this point on he continues to imitate the

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speech he hears, although he also invents words of his own. But his perception of speech is faulty and his articulation inept. He gains a clearer concept of words and a greater skill in articulating sounds only with practice. It is no wonder, then, that in the early stages his speech may be incomprehensible. Such a severe dyslalia is termed *idioglossia*.

If we examine the lingual phenomena presented by a child in the physiologic period of dyslalia, we observe the following manifestations: omission and reduction, reduplication, assimilation, sound substitutions, metathesis, and analogy.

(1) *Omission and reduction* is characterized by the omission of sounds and syllables from words, usually the difficult sounds, and the unaccented syllables. For instance, *boom* is said for broom; *g'ome* for go home; *pa-bu* for pocketbook.

(2) *Reduplication* consists in the repetition of simple syllables to form words. For instance, *moo-moo* is said for cow; *bow-wow* for dog. These words imitate the sound of the thing indicated.

(3) The child who says *poom* for spoon demonstrates assimilation combined with omission. *Assimilation* is the modification of one sound by another related in position or formation. Thus "s" is omitted from *spoon*, and "n" is labialized to become "m" to conform to the labial sounds "oo" and "p".

(4) The various sounds comprising the velar, labial, and palatal groups are related in their mode of articulation. To one inexperienced in making these sounds, *substitutions* are common. Those most frequently seen are:

- d for g (do for go)
- t for k (tat for cat)
- d or t for th (dis for this; tree for three)
- f for th (free for three)
- b for v (bery for very)
- w for r (wun for run)

The following sentence demonstrates omission of sounds and sound substitutions. Do 'ome an' ta' free tats wif oo for "go home and take three cats with you."

(5) Another manifestation of dyslalia is *metathesis*, which consists in the transposition of sounds or syllables in a word, or the transposition of words in a sentence. An example

of transposition of sounds in a word is *efelant* for elephant; *perscribe* for prescribe.

(6) Finally there is *analogy* which constitutes the confusion of words due to a similarity in form, meaning, or syntax (enemy for anemone; wrench for wring; foots for feet).

Omission and reduction, assimilation and sound substitutions are the more common of these phenomena seen in physiologic dyslalia.

Pathologic Dyslalia. At about the age of three the child is usually proficient enough to articulate words clearly. If, however, he continues to be dyslalic, the condition is pathologic and a cause should be sought. A diagnosis may be made before this time if at the age of two, let us say, the child has not progressed beyond the stage of primitive sounds or fails to comprehend speech.

The manifestations of pathologic dyslalia are the same as those of physiologic dyslalia. The distinction lies in this: normally by the age of three the child has completed the period of physiologic dyslalia, whereas in the case of pathologic dyslalia the speech development is retarded. The length of time it will take such a child to acquire normal speech depends on the cause, and in some cases normal speech may never be acquired.

Pathological dyslalia manifests stages of development comparable to the normal development of speech, as is evidenced in these examples. A child who shows severe mental retardation, and would be classed as an idiot, may never advance to the stage of speech comprehension, or if he does, only understands a few simple commands. If the mental retardation is less severe, he may be able to repeat words in a meaningless fashion (echolalia), or utter speech which is more or less unintelligible (idioglossia). His comprehension is better. In a milder case, speech is well understood, but articulation dyslalic. With training, speech may become normal or defective only in the articulation of single sounds. This latter stage, the defective articulation of single sounds, is known as partial dyslalia, in contradistinction to universal dyslalia, which denotes a more universally defective speech. The stages of pathologic dyslalia, then, range between mutism and normal speech, and may be enumerated as follows: the articulation of primitive sounds,

echolalia, idioglossia, universal dyslalia (characterized by omission and reduction, etc.) and partial dyslalia (the faulty articulation of single sounds).

Etiology of Dyslalia. For the normal development of speech, an intact speech arc must exist. The organs of sight and hearing, the auditory and motor memory centers, the cerebral cortex, the organs of articulation and the various pathways connecting these areas and organs must be intact. Interruption of the arc at any point interferes with the development of speech.

If the infant is congenitally deaf, or hearing is lost before speech is established, deaf mutism results. If hearing becomes impaired due to otitis media or meningitis, speech is improperly received and faulty reproduction ensues. If mental deficiency exists, the child has not the cortical cells wherewithal to acquire speech, or speech is delayed in onset and development. If the auditory or motor memory centers are congenitally affected, auditory or kinesthetic speech memories cannot be stored properly. The peripheral organs of speech may be malformed as in cleft palate or cleft lip, and psychologic factors may exist to prolong the stage of dyslalia. The causes of pathologic dyslalia may be listed then as follows:

- (1) Impaired hearing
- (2) Mental retardation
- (3) Congenital auditory imperception (congenital word deafness)
- (4) Congenital articulatory dyskinesthesia (kinesthetic dyslalia)
- (5) Congenital organic defects of the organs of articulation.

Psychologic Dyslalia. A child may continue to lall, although he is able to articulate well, in order to retain his position as baby of the family. Many parents indulge in baby-talk and enjoy hearing it in their children. Other parents make it unnecessary for the child to express himself clearly in order to obtain what he wants. Dyslalia due to these causes is psychologic in character. A case in point may be cited. A boy of eleven, whose father died when he was four, became attached to his mother through the attentions she showered on him after her husband's death. He was not

weaned from the bottle until he was six, and slept with his mother until recently. At school he is bright and his speech perfectly normal. At home he lapses into baby-talk. He says, me for I; seep for sleep; one-two for twelve; evven for eleven, etc. A characteristic sentence is "me wants go to seep."

Impaired hearing and mental retardation are common causes of dyslalia and must always be ruled out before a final diagnosis is made. A developmental history and the fascies of the child are of great aid in diagnosing mental deficiency. The mentally retarded child may show varying grades of speech disturbance, as outlined, ranging from primitive sounds to normal speech. Without any reference to the cause of the mental deficiency, the speech of the backward child, provided he has received adequate attention, is a good indication of his mental capacity.

A history of otitis media or meningitis is of value in diagnosing impaired hearing. Dr. Atwood and I recently studied a group of children at St. Michael's School in Paterson (through the coöperation of the Passaic County Tuberculosis and Health Association) manifesting speech defects and were surprised at the incidence of hearing impairment. Dr. Atwood will discuss this phase of the subject more fully.

Kinesthetic Dyslalia. I have coined the term kinesthetic dyslalia to denote a common group of speech disturbances characterized by a motor ineptitude in the articulation of sounds. The child is mentally normal. In the ordinary case the stage of physiologic dyslalia is prolonged. His articulation may be so indistinct that he seems to be talking a foreign tongue. In the extreme degree, he may only be able to utter a few sounds (a congenital motor aphasia), although he understands everything that is said to him. The defect is a motor one, an inability to store the motor memories of articulation. With training, these children acquire more or less normal speech, although defective articulation of single sounds may persist, a partial dyslalia.

Congenital Auditory Imperception. On the auditory side, comparable to the motor handicap just described, is congenital auditory im-

perception. A comprehension of the spoken word, and sometimes of ordinary sounds, is lacking. In the extreme degree, a picture of congenital word deafness is seen. Such a child is bright, extremely active and his attention easily distracted, so that his manner has been described as "bird-witted". This child passes through the stages of lingual development described, and the dyslalia he presents does not differ from that of any other group. He can be taught speech comprehension by means of visual and motor instruction, and thus acquire normal speech.

Peripheral Organic Dyslalia. The peripheral organs of articulation complete the speech arc. The teeth, palate, tongue and lips must be normal as well as the other parts of the arc for the normal production of speech. Congenital affections of these organs, such as cleft palate and cleft lip, interfere markedly with normal speech development. Only a word can be said about these defects. Concerning cleft palate repair, I feel that the repair itself is of more importance than the age at which the operation is done. The operation to close a cleft is more successfully performed in childhood than in infancy (Dorrance). The most important thing is to give the child a soft palate that will be long enough and flexible enough to approach the posterior pharyngeal wall and prevent the escape of air into the nose during the articulation of oral sounds.

I would like to emphasize deformities of the teeth as another phase of peripheral defects. The presence of dental defects must not be accepted, without further investigation, as the cause of a child's speech defect. Such irregularities may have nothing to do with the disturbance of speech. Many children have widely spaced teeth or malocclusions and no speech defects. On the other hand, children with speech defects and malocclusions may have impaired hearing which is the primary cause of the disturbance of speech. The dental irregularities are only of secondary importance. Mental retardation or motor ineptitude may be the cause rather than the malocclusion, or these factors may be contributory. I might also add, that I have never seen a speech defect due to so-called "tongue-tie".

SUMMARY

Faulty speech, lalling or dyslalia is normal to the child who is passing through the period of speech development. If the onset of speech is retarded or the period of dyslalia prolonged beyond the third year, we are dealing with a pathologic condition and a cause should be sought. Dyslalia has, therefore, been divided into two forms, that which is physiologic, and that which is pathologic. The manifestations of both forms are the same. The distinction lies in the time of onset of speech and the time required to accomplish normal speech. Depending on the cause, normal speech may never be acquired. The causes of pathologic dyslalia are impaired hearing, mental retardation, congenital auditory imperception, motor ineptitude, and peripheral organic defects.

DISCUSSION

Dr. Maurice L. Rippes, Elizabeth: I had a patient who would always refer to an object by the same monosyllabic syllables. He would call an automobile a "lo-lo" and he always referred to me as "do-do". Daddy was always "do-daddy", and the dog was "bo-ba", and there were several other words that he applied—always the same words to the same things, specifically. Radio and water each had a specific sound and he seemed to know what they were and what they meant, merely using his own particular terminology. His hearing, as far as I could determine, was good. When this child was about the age of three, he suddenly began to talk normally.

Dr. Lathrop, Plainfield: Would Dr. Wolf kindly say a word more about tongue-tie?

Dr. Wolf: Normally, the tip of the tongue in the infant is short, but despite what seems to be a tongue-tie, the tip elongates as the child grows older. When a mother brings a child to you for tongue-tie, she expects you to do something about it. If you won't, some one else will. But the pernicious thing is that so many speech defects are innocently laid to tongue-tie. If a child can protrude his tongue between his teeth or touch the anterior part of the hard palate with the tip, he can manipulate it sufficiently to articulate sounds well, unless some other cause exists to interfere with speech development. Cases of congenital aglossia have been recorded where only a stump of tongue is present and yet fairly good speech can be acquired. Of course the tongue may be congenitally bound down, as it may be later by growths, but this is rare.

Dr. Rippes' case was probably one of physiologic dyslalia bordering on idioglossia. His speech became normal within physiologic limits. If it can be established that the hearing is normal, and that the intelligence is normal, two common and important causes of retarded lingual development

are ruled out. Two other forms may occur in a child who has normal hearing and normal intelligence. One is a motor ineptitude, and the other an auditory imperception. No two individuals are the same as concerns their inherent capacities. Some are skilled with their hands, others have a keener musical sense or a finer appreciation of colors than their fellows. The same applies to speech. Some children are delayed in lingual development because they cannot comprehend the meaning of words, or even ordinary sounds. In the extreme degree a congenital word-deafness (congenital auditory imperception) exists. On the motor side an analogous picture may be seen. A child may be inept in articulation in the same way as he may be inept with his hands. In the extreme degree, if the motor memory for words is inadequate, a congenital motor aphasia may be observed. I have seen such a child. His hearing and intelligence were normal and yet he was unable to articulate words. His comprehension of speech

was good. He is now six years old and has been slowly building up a vocabulary. His speech is lalling and shows sound substitutions.

Congenital auditory imperception (congenital word deafness) is a rarer condition than motor ineptness of articulation. These children also have normal hearing and intelligence, but no comprehension of the meaning of words. Hence the delay in speech development. They are bright, very active and unable to focus their attention on any object for more than a moment. They have, therefore, been termed "bird-witted" (Ewing). They may be mistaken for deaf mutes, except that one observes in the course of time that they do hear. I have had the good fortune to see two of these cases, but have been unable to follow them. Ewing has observed one case for years, and when speech was accomplished by means of visual and motor methods, hearing was found to be normal as tested by the audiometer. Cases of this nature may exist in milder degrees.

A UNIQUE OPERATION FOR APPENDICITIS

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The discussion of appendicitis, I believe, calls for some explanation at the present time, as it has been worked out rather thoroughly during the past 2 or 3 decades. However, during the past 12 years, in doing this operation a great number of times, there has gradually evolved a procedure which has given me a great deal of satisfaction.

There is nothing new or startling about this procedure but there are certain particular points about it which I believe can be advantageously stressed. I am going to consider only those particular factors which, it seems to me, have been almost unfailingly satisfactory in making this operation safe.

In diagnosis, the points I have stressed are: the patient does not seem very ill; the pain is seldom severe; there is nearly always nausea and frequently vomiting; constipation occurs in a large majority of cases but, in my experience, diarrhea has been extremely rare.

The most important diagnostic aid, in my experience, has been point tenderness. I frequently ask the patient to take one finger and press over his abdomen. Frequently he will stop at, or very close to, the classical McBurney's point. Then with one finger I very care-

fully and at first very gently, palpate the abdomen, beginning on the left side and coming around over the pubes. If the point of maximum tenderness lies at or within 2 cm. of McBurney's point, I feel that the patient has a diseased appendix. I have very, very seldom seen this fail.

Preoperatively, in adults, I use morphia sulphate $\frac{1}{4}$ gr. and atrophin sulphate 1/150 gr. For anesthesia I use straight nitrous oxide-oxygen gas and feel that this is a marked advance over ether or spinal anesthesia. The patient rarely vomits and is free from annoying complications. Occasionally, I employ regional anesthesia of $\frac{1}{2}\%$ novocaine. This works fairly satisfactorily, but when traction is made on the mesentery the patient almost invariably complains of epigastric distress, pain and nausea. Spinal anesthesia I consider too drastic for simple appendectomy, although employed frequently by me for more severe operations.

I am going into the technic of this procedure carefully, as I believe that the consideration of each step gives certain advantages. My incision measures from 2 to 5 cm. in length and runs almost transversely across the abdomen. I try to get it in the natural skin fold so that when it is healed there is no pulling

apart of fibers, and in a few months it is nearly invisible. The fascia of the external oblique muscle is nicked with a scalpel, the handle of the scalpel is then inserted and the fascia gently separated with no cutting across the fibers. A small retractor is inserted under the mesial edge of the fascia and a slight nick made in the internal oblique muscle. The handle of the scalpel is again inserted and the internal oblique and transversalis muscles are gently separated, thus exposing the peritoneum. The peritoneum is freed and loosened by sweeping the finger around. This makes it very much easier to close at the end of the operation. A narrow-bladed rather long retractor of the Deaver type is inserted after the peritoneum is opened and retraction gently made mesially. This draws the small intestines toward the mid-line and the blue cecum is often visible. This is gently brought up with the finger or a clamp until the appendix comes into view. The cecum is then replaced in the abdomen, the mesoappendix is clamped and tied serially, and a linen purse-string suture is placed about the appendix with a small cutting-edge straight needle. The appendix is girdled, crushed, clamped, ligated, cut, and treated with carbolic-alcohol technic. It is then grasped with a mosquito forceps and, after cutting the ligature about the base of the appendix, the stump is inverted and closed with the linen purse-string suture. The instruments used in this procedure are discarded with the appendix. In closing the peritoneum I use a

continuous suture, 1 or 2 interrupted sutures for the muscles, fascia and subcutaneous tissues, and Michel clips for the skin. I usually employ No. 1 chromic catgut throughout but also use fine silk at times.

Objection has been made to the tiny incision I sometimes employ. These cases are usually in young adults with no other evidence of pathology and in women through this incision I can nearly always palpate the uterus, right tube and ovary. There is very little else to consider in this location. I do not believe it is justifiable to make an incision large enough to examine the upper abdominal organs. Occasionally I find it necessary to enlarge my incision due to one cause or another but this is very easily accomplished. It seems to me that the crux of the matter is in accurate diagnosis.

The postoperative care is simple. I use no purgative but give enemas when indicated. The patient usually goes home within 5 to 8 days and is able to do heavy work in 2 weeks.

In summarizing, the points I would like to stress particularly are: the use of nitrous oxide-oxygen gas; the skin incision along the natural skin fold; the very small incision; the fascia and muscle splitting rather than cutting across the fibres; the stretching of the peritoneum; exposure of the cecum by mesial retraction; inversion of the stump through a linen purse-string suture; the very short time that the patient is compelled to remain in the hospital and away from work; and the remarkably little distress suffered postoperatively.

UROGRAPHIC FINDINGS IN TOXEMIAS OF PREGNANCY

By ROBERT B. WALKER, M.D., F.A.C.S., New Brunswick, N. J.

The appended observations in cases of the toxemias of pregnancy were begun six years ago at the New York Post-Graduate, and the Middlesex General Hospitals, supplemented by certain clinical and laboratory data noted in toxemic patients encountered in private practice. Patients frequently entered the female cystoscopic clinic complaining of symptoms

referable to the uro-genital tract, stating that the urinary disturbances developed during the latter trimester of pregnancy, or shortly after labor. In all such cases a systematized investigation of the urinary tract was made, including the following procedures:

(1) Cystoscopy of the urinary bladder and intravenous renal function test, indigo-carmin being used most often.

(2) Catheterization of the ureters to ex-

clude obstruction by calculi, stricture, or extrinsic pressure.

(3) Collection of urine directly from the renal pelvis to detect evidence of pyelitis, pyelonephritis, etc.

(4) Culture of the urine.

(5) Pyelography (in most cases).

As a result of these diagnostic steps, it was apparent that many patients had a residual pathologic condition of the kidney. The most frequent abnormalities were pyelitis, pyelonephritis, stricture or dilation of the ureter, angulation and kinking of ureter, pyelectasis, and undue delay in elimination of indigo-carmin from the ureteric orifices. After establishing a definite diagnosis, appropriate treatment was instituted by providing ureteral drainage and lavaging the renal pelvis with five per cent neosilvol.

CLASSIFICATION OF TOXEMIAS

The toxemias of pregnancy may be divided clinically into two groups; 1, those which arise in the early months of gestation; and 2, the more severe types which are manifested during the latter trimester of pregnancy. The early cases include hyperemesis gravidarum, mild and severe; while those arising in the latter months may be subdivided as pre-eclampsia, eclampsia, and chronic nephritis with hypertension or eclampsia.

Many theories have been advanced concerning the causative factors of toxemia. Prutz in a review of 360 autopsies after eclampsia found renal involvement in all but seven cases. Pollack, of Vienna, confirmed these findings and noted renal involvement in 98 per cent of a series of 139 cases. Other writers state that the frequency of renal infection in pregnancy is not generally appreciated, and express the belief that the process is hemotogenous and originates in the colon. The etiology of hyperemesis gravidarum has not been satisfactorily explained, although recent clinical evidence supports the proposition of carbohydrate deficiency, as suggested by Duncan, Harding, and Titus.

During the past four or five years a number of cases have come under my observation which have not responded to carbohydrate therapy. One patient presented particularly interesting

radiologic findings. There was a definite torsion or kink of the right ureter at the ureteropelvic junction, and the ureter was irregular in outline below this point, indicative of a ureteritis. The x-ray findings in another patient with a very pronounced hyperemesis were: calculus in the lower pole of the right kidney and blunting of the major and minor calyces, together with dilation and kinking of the ureter to form an S curve one-half inch below the ureteral pelvic junction.

In ten patients having marked hyperemesis no routine urological check-up was done, although most of them were benefited by catheterization of the ureters, followed by dilation with either number 8 or 10 Braasch ureteral bulbs. One patient was given carbohydrate therapy intravenously, saline by hypodermoclysis, and the usual complementary treatment, without improvement. After catheterization and dilation of the ureters, vomiting ceased within 24 hours.

Similar urographic studies were made in a pre-eclamptic group of four patients, presenting the usual symptoms of pre-eclampsia—elevation of blood pressure ranging from 160/90 to 186/110, two to four plus albumin, occasional hyaline and granular casts, headache, diminished urinary output, edema, visual disturbances, and increase of body weight.

Prompt relief in the pre-eclamptic patients may be attributed to the fact that there was obstructed ureteral drainage, as shown by pyelography. With proper ureteral treatment to relieve stricture of the ureter and the faulty drainage, the clinical end-results were remarkable. The systolic blood pressure in two instances dropped 60 mm. within 24 hours.

Five patients in the chronic nephritic group with hypertension were studied during the latter trimester of pregnancy, the average non-protein nitrogen being 40, and the urea nitrogen 26. Hypertension and albuminuria appeared earlier in pregnancy in this group compared with the pre-eclamptic type. One patient had a blood pressure reading of 176/90 and four plus albumin in a catheterized specimen from the bladder at the second month of gestation. Renal lavage was instituted and the blood pressure reading within one week was 140/80. Ureteral catheterization and lavage

were repeated in another week, and the blood pressure dropped to 132/76. A catheterized specimen at this time showed only a faint trace of albumin. A carious tooth was extracted and the subsequent ante-partum and post-partum convalescence were normal, the blood pressure averaging 130/80, with a faint trace of albumin in the urine. Two years later the same patient developed headache, a blood pressure of 170/90, three plus albumin; and x-ray and pyelographic studies revealed a renal calculus. Conservative ureteral measures were utilized and the patient passed the calculus, whereupon the blood pressure dropped to 132/80 and the urine became albumin free.

An x-ray and pyelogram of another patient in this group showed a hydronephrosis, loss of cupping of the minor calyces, and a definite kink of the ureter one-half inch below the renal pelvis. A second kink of the ureter was noted at the right sacro-iliac joint, which was the cause of dilation of the ureter above the point of constriction. Treatment in such a case is not so efficacious as in the pre-eclamptic group, although the effect is sometimes beneficial.

Eclampsia was not studied from the urological viewpoint, although urographic studies might afford some clue regarding its causative factor.

Most obstetricians rely upon conservative treatment, urinary antiseptics, and postural drainage in pyelitis of pregnancy. My experience, however, has led me to add ureteral drainage by an indwelling catheter, and lavage of the renal pelves, as well as dilation of the ureters when indicated. These procedures are especially advantageous in the severe type of pyelitis and pyelonephritis of pregnancy, either ante-partum or post-partum. Clinically, the patient improves more rapidly under this treatment and recovers within seven to ten days.

The following data exemplify the necessity for thorough treatment in many cases of pyelitis of pregnancy. One patient who had had a persistent albuminuria for the previous four years suddenly developed chills and a temperature of 104° at the fourth month of gestation. A catheterized specimen of urine showed four plus albumin, 1010 specific gravity, one plus red blood cells, and four plus pus cells. X-ray examination of the genito-urinary tract re-

vealed the right kidney slightly enlarged and low in position, with a constriction of the ureter opposite the transverse process of the fifth lumbar vertebra, as well as a kinking of the ureter at the renal pelvis. The major and minor calyces were blunted and dilated. These findings were evidence of early hydronephrosis. The left kidney was normal, although the ureter was kinked opposite the third lumbar vertebra. Treatment included an indwelling catheter for two days, lavage of the renal pelvis, and dilation of ureter. The patient was discharged from the hospital after seven days. A catheterized specimen three weeks later was free from albumin, and the patient had no renal calculi have been demonstrated and other ureteral conditions appropriately treated.

RENAL FUNCTION STUDY AND RENAL PELVIC CAPACITY

The indigo-carmin elimination is frequently delayed in cases of pernicious vomiting of pregnancy, especially when the renal pelvic capacity is increased. Whether there is a definite time-ratio of indigo-carmin excretion to the degree of pelvic dilation has not yet been established. Other writers have noted delay.

Pre-eclamptic patients show a marked increase in the time of indigo-carmin ejection from the ureteral orifices, particularly on the right side. In one instance the time of excretion was nine minutes, and the renal pelvic capacity was 25 cc. In another case the functional time was 27 minutes and the pelvic capacity was 65 cc.

Indigo-carmin tests in patients having chronic nephritis with hypertension showed the indigo-carmin elimination to be delayed for a longer period and pelvic capacity slightly greater than in those in the pre-eclamptic group. After delivery the return to normal function and pelvic capacity was slower than in the previous group. This is well illustrated by one patient in whom prior to delivery the indigo-carmin time was, right 20 minutes, left 4 minutes, and the right pelvic capacity 30 cc. Three months post-partum the indigo-carmin function time was, right 10 minutes, left 4 minutes, and the right pelvic capacity 18 cc.

At the present time I have under observation a para six, blood pressure 140/90, 6

months pregnant, who shows no elimination of indigo-carmin from the right ureter in 25 minutes, with a pelvic capacity of 72 cc. on the same side, while the indigo-carmin shows normal elimination percentage and a normal pelvic capacity on the opposite side.

PATHOLOGY OF URETERAL DILATION

It has long been recognized that ureteral dilation occurs during pregnancy, especially on the right side. Olshausen noted this pathologic alteration in 18 per cent of cases by simply making a gross examination of the ureters at autopsy. Utilizing modern methods of intravenous urography and retrograde pyelography, the condition is found very frequently. H. P. White and other writers contend that some previously existing inadequacy in the ureteral caliber should be considered the principal cause of dilation, and that such obstructions are more often present than are generally believed. My personal studies in post-partum women who have urinary disturbances warrant similar conclusions.

Hofbauer, in 1928, when seeking a plausible explanation of dilation of ureter with concomitant pyelitis in pregnancy, demonstrated by histo-pathological examination of the ureteral tract and bladder that hypertrophic changes occur in the musculature, associated with hyperplastic changes of the connective tissue. He believes that these hyperplastic changes are essential factors in narrowing the lumen of the pelvic portion of the ureter.

In several of my patients there was definite urographic evidence of stricture of the ureter which had probably existed prior to pregnancy. On attempting to pass a number 5 ureteral catheter considerable difficulty was experienced. Undoubtedly the structural changes in the ureteral wall (intravesical and juxta-vesical portion) can occasion a stenosis and thus diminish the normal physiological contractility of the ureter. It should be remembered that there is a certain degree of anatomical narrowing at these points.

DEDUCTIONS

The foregoing therapeutic measures include methods well known as useful in the treatment of pyelitis of pregnancy. In addition, I

have shown by urography that pathological alterations in the urinary tract exist in some cases of hyperemesis, and with appropriate treatment marked clinical improvement occurs. Very few references to similar observations are found in the literature. Likewise, urographic studies of pre-eclamptic and nephritic patients seem to warrant further investigations and treatment such as I have indicated. I would emphasize the paramount importance of ureteral constrictions, especially in the infra-region of the pelvic portion of the ureter, as essential factors in producing clinical symptoms in pregnancy. I believe that these contributory physical conditions of angulation, dilation, and impaired function, justify further study and interpretation.

CONCLUSIONS

1. Uro-genital pathology is frequently found in patients who have manifested toxemic symptoms during pregnancy.
2. Urographic studies in such cases warrant the opinion that in some instances pathological alterations existed prior to pregnancy.
3. Indigo-carmin elimination is delayed in the toxemias, and parallels to a certain degree the pathology disclosed by urography.
4. Return of physiologic function and normal renal and ureteral capacity occurs more rapidly in the milder than in the severe toxemias.
5. The inadequacy of the usual diagnostic and therapeutic measures in many cases of toxemia leads to the belief that additional procedures may prove of value.
6. Suggestions based on urographic studies and careful treatment in the several varieties of toxemia are offered.
7. Urography occasionally will reclassify a patient in the chronic nephritic group, after renal calculi have been demonstrated and other ureteral conditions appropriately treated.
8. Certain cases of the toxemias of pregnancy have been successfully treated, and the diseased kidney of pregnancy should not be so designated until a thorough investigation of the urinary tract has been made.

DISCUSSION

Dr. I. J. Strumpf: In toxemias there occurs dilation of the ureters and the kidney pelves; and the urine contained in these dilated organs is sluggish urine. Were these findings peculiar to toxemias alone, it would afford considerable satisfaction to those who believe that the kidney is the organ at fault in the etiology of the toxemias of pregnancy. But this is not so. In apparently normal pregnancies we, at Margaret Hague Hospital, have been able to demonstrate that there is a symptomless dilation of ureters and kidney pelves in 92 per cent of a carefully controlled series of 50 cases. In other words, almost every pregnant woman, whether she exhibits symptoms attributable to her urinary tract or not, will show upon urographic visualization, kidney pelves and ureters which are dilated and ureters which are displaced, tortuous, or kinked. Shumacher, Guthmann, and Ehrhardt in Germany, Baird in England, Duncan and Sent in Canada, Mengert, Lee Cornell Warfield, Crabtree and a host of others in this country have demonstrated these findings repeatedly. And that is not all. In our series dilated structures which appeared on x-ray to be so pathological were found to have involuted in 100 per cent of cases to normal size, usually by the ninth day following delivery.

In the light of these facts we would expect to find in toxemias exactly what Dr. Walker did find. A discussion as to whether this dilation and hypertrophy is a result of pressure on the urinary conducting tract, or it is due to some factor inherent in the pregnancy itself, would take us too far afield. Suffice to say that hydroureter and hydronephrosis are common and apparently normal findings in the pregnant state.

Dr. Walker has treated women with toxemias of pregnancy and has given them symptomatic relief by ureteral catheterization and pelvic lavage, or drainage, and this again opens up an interesting field for speculation. In 1927 Kahn at Postgraduate Hospital reported a series of 52 cases of mild and moderately severe toxemias of pregnancy, in 40 of whom he was able to demonstrate some evidence of kidney derangement following thorough urological study. In the urine drained from the pelves of these women he was able to find white blood cells, staphylococci, coliform organisms, etc., in addition to anatomic changes, such as kinking, ptosis, and stricture. With repeated pelvic lavage, oral antiseptics, and colonic irrigations he was able to terminate satisfactorily cases of toxemia of pregnancy which ordinarily would have been terminated by therapeutic abortion. We were stimulated by his findings of symptomatic relief by renal pelvic drainage, and have in a modest way been working along these lines; and as far as we have gone our findings might be summarized about as follows:

In those cases of toxemia of pregnancy on a nephritic basis where the patient already exhibits eyeground changes, a mounting hypertension, and diminished renal function, then kidney pelvic drainage has no demonstrable effect on the toxemia nor on the hypertension, and the patient usually shows

progressive kidney damage as the pregnancy advances. Should, however, an acute renal pelvic inflammatory process be superimposed upon such a kidney, then ureteral catheterization with pelvic drainage becomes a therapeutic instrument of considerable value.

Again, in those cases of toxemia of pregnancy of the pre-eclamptic type with symptoms of nausea, vomiting, epigastric distress, visual disturbances, and headache, we have been able to get some symptomatic relief and a fall in blood pressure only in those cases where, as Dr. Kahn found, there was evidence of an inflammatory process present in the renal pelvis; and where white blood cells and organisms were present in the urine obtained by catheterization of the renal pelvis, even though the patient was temperature free and routine examination of the bladder urine was negative. In other cases of the same sort where no pathological findings were noted after thorough urological workup, it was also found that the blood pressure remained the same and the vomiting and nausea persisted even following the catheterization.

Dr. Robert Lewis McKiernan, New Brunswick: If more attention is paid to the urogenital tract right through the toxemias of pregnancy, the mortality might have been lowered definitely and materially. It shows the necessity for early and frequent urine examinations. If any abnormal findings are discovered, cystoscopic examinations may be indicated. The general practitioner may be fearful of cystoscopic examination of these patients because it might induce abortion or miscarriage. In the hands of a skilled operator, there is no such danger.

It has been emphasized in the past a great deal by urologists that constipation has contributed to focal infection of the kidneys. Focal infection from the teeth and the tonsils is one of the causes in these types of malignant hypertension to which Dr. Walker referred. Malignant hypertension is a persistently high blood pressure which in the past we have been unable to explain. Mechanical obstruction of the ureter can take place in pregnant women; their blood pressure goes up and they develop eclampsia. That is one of the most distressing conditions in gynecological work. These eclampsias can be prevented by urogenital examinations. In this way, we may be able to reduce the maternal deaths so prevalent in this country.

Dr. R. B. Walker: I feel that in certain groups of inflammatory conditions of the renal pelvis which are probably occasioned by stenosis or improper drainage in the region of the lower ureter, mechanical dilation of the ureter will be of benefit. Some patients are entirely relieved; others are relieved for a short time. I think this therapy may have some value in the treatment of eclamptic patients, but I have not utilized this procedure. In the chronic nephritic patients in whom I have employed this treatment, I have had some fair results. In a few cases, they were improved.

RENAL EMBRYOMATA IN INFANTS AND CHILDREN

By MEREDITH F. CAMPBELL, M.D., Montclair, N. J.,

Attending Urologist, Babies' and New York Nursery and Child's Hospitals; Assistant Visiting Urologist, Bellevue Hospital, New York

Almost all solid tumors of the kidney in infants and children are congenital embryomata, the so-called congenital mixed or Wilm's tumor. They are the commonest neoplasm of the abdomen in the young in whom their incidence (20% of all tumors in juveniles) is exceeded only by growths of the eye and orbit (52%).

Pathology. Although a few small renal embryomata have been observed, the vast majority are clinically recognized because of their large size. Growth of the tumor is characteristically rapid and is sometimes enormous. In a child in my series, the tumor accounted for approximately one-half of the body weight.

The tumor surface is often smooth, but, as the growth enlarges, may become irregular and nodular. Occasionally, it is cystic. By the time the lesion comes to operation or autopsy most of the organ is invaded or compressed and the normal renal outlines are lost. On section the tissue appears soft, of brain-like consistency, grumous, gelatinous, semi-translucent, edematous or fibrous. Cystic areas containing clear or straw colored fluid may be found.

Symptoms. A tumor in the kidney region is the most common symptom of renal embryoma. This is in marked contrast to hypernephroma, in three-fourths of which cases the initial symptom is hematuria. In embryoma the mass is usually noted by the child's parent or, rarely, during a physical examination. Yet, a 4-year-old boy I saw, was the first to call attention to his tumor.

These tumors rarely cause symptoms until large and the health of the child until this time is usually good. Renal pain occurs in about one-third of all cases and parallels the firmness of the tumor. Metastases cause distant pain. Hematuria occurs only in about 15% of all cases and may be microscopic or macroscopic. Disturbances of urination such as frequency, nocturia, dysuria, urgency or polyuria occur in about one-third of all cases. They are usually reflex, lower-urinary tract manifestations. As the growth enlarges, symptoms due to secondary compression of the diaphragm or gastrointestinal tract may be manifested by respiratory or cardiac embarrassment or by acute gastrointestinal disturbances on the one hand or malnutrition disorders on the other. Symptomatic varicocele of sudden appearance is always suggestive of renal tumor and is mechanically produced by tumor compression of the spermatic vein or, on the left side, by plugging of the spermatic vein orifice by tumor within the renal vein. With the onset of compression symptoms, the downward course is rapid. In one-third of these cases, renal

tumors cause febrile disturbances which may be of the continuous typhoidal or recurrent malarial varieties of chronic low grade.

Diagnosis. The diagnosis is made chiefly by palpation of a tumor in the kidney area but this should always be confirmed by pyelographic study. Excretion or intravenous urography is occasionally a valuable diagnostic aid but with obliteration or extreme compression of the pelvis or with a greatly diminished renal function, no pelvic dye shadow may be obtained. Retrograde pyelography is the method of choice in the diagnosis of renal tumor. The changes in pelvic outline suggestive of renal new growth are: (1) elongation of the calyces, (2) filling defect of the pelvis, (3) enlargement of the pelvis with or without evidence of alteration of the pelvic capacity.

Differential Diagnosis. Although a firm loin tumor in a child is most likely to be a renal neoplasm, in my experience neuroblastoma of the adrenal has caused the greatest differential difficulty. In going over the records at the Babies' Hospital in New York I found that adrenal tumors occurred about one-half as often as renal tumors (10:22). However, renal tumors may cause a fullness but do not bulge into the posterior loin as large adrenal tumors so often do. Other conditions to be differentiated are: hydronephrosis, lymphosarcoma of the retroperitoneal lymphnodes, hepatic tumors, splenic tumors, fecal and intestinal tumors, mesenteric cysts, polycystic disease, tuberculous peritonitis. Yet, in all of these conditions the history, physical examination and more particularly the intelligent interpretation of properly performed retrograde pyelograms should point to, or exclude, the kidney. In polycystic renal disease, for example, the findings on loin palpation and the pyelographic changes suggestive of tumor are almost always bilateral. Although an exploratory operation for diagnosis is often performed, an intelligent urologic examination may save the child needless surgery. In urologic disease, exploratory operations for diagnosis suggest nineteenth-century surgery.

Prognosis. The ultimate mortality in renal embryoma in children is about 95%. The child not operated upon will live about 8 months; the child operated upon will live about 16 months. Yet operation offers the only hope. Only 2 of 22 cases at the Babies' Hospital in New York lived more than 2 years.

Treatment. "In the treatment of these very malignant growths we come against a peculiar paradox. The disease is one with an insidious onset producing difficulties for an early diagnosis, and yet to have a chance to cure, the diagnosis must be made very early and the extirpation complete" (Hinman and Kutzman). Operation offers the only hope of cure.

DIAGNOSIS AND TREATMENT OF CANCER OF GALL-BLADDER

By B. B. RANSOM, JR., M.D., Maplewood, N. J.

Cancer of the gall-bladder is not of common occurrence, but its existence is of sufficient importance to warrant brief consideration. It has been estimated that from 0.5 to 5% of all cases of biliary tract disease are malignant. Finisterer found in 1544 autopsies on men over 39, 3 cases of cancer of gall-bladder. In 1929 postmortems on women of the same age, there were 25 cases, showing a relatively higher incidence in women. In 557 carriers of gall-stones there were 24 cases of carcinoma, indicating a danger coefficient of 4.3%. Judd, of the Mayo Clinic, reported that in cases of gall-bladder disease operated from 1907 to 1930, there were 1.4% malignancies. In 1919, McCarthy reported from the same clinic, that in 4998 gall-bladders removed at operation, there were 24 cases of malignancy, 0.5%; of these 212 cases, 74% occurred in women.

The practical deduction from these statistics is, that an individual over 40 years of age, suffering from the presence of gall-stones, incurs a risk of future malignancy, not altogether negligible. The incidence of malignancy at the present time may be found less, because of the fact of more frequent performance of cholecystectomy during recent years.

In a series of 449 cases of gall-bladder disease treated surgically at the Orange Memorial Hospital in the past 5 years, there were 3 cases of cancer. The etiologic relationship between the presence of stones and the existence of malignancy, is worthy of consideration. In the records of autopsies alluded to, 95% of all cases of malignancy of gall-bladder contained stones. The cases coming under our observation have had stones. The co-existence of persistent irritation and chronic infection, which exist in cholelithiasis, supplies important elements in the production of cancer. Burrows made an experimental study on 33 guinea pigs, in an effort to determine the relationship between the presence of calculi in the gall-bladder and the occurrence of cancer in this organ. Stones removed at operation on human subjects were introduced into the gall-bladder of the animals. None of these animals succumbed to cancer and in none were cancer cells found microscopically. Two of the animals were well 3 years after the introduction of the calculi. In the 31 cases, examined after death, a condition of hyperplasia was found and the gall-bladder become hard and adherent and white in color. Such animal experiments require further

proof than those supplied by the microscope. In none of these cases studied could a diagnosis of malignancy be substantiated. These factors would justify the prompt resort to surgery, when diagnosis is certain.

Symptoms. The early manifestations are those characteristic of cholecystitis: indigestion, flatulence, eructations of gas, colicky pain, etc. Later, local pain and tenderness and a palpable tumor, which latter may be the first definite sign observed. In advanced cases, loss of weight and strength. If the disease has extended to the bile ducts, jaundice. Anemia is not a constant symptom. Tenderness in the right hypochondrium and palpable liver margin are observed. Luger has called attention to the fact that the firm smooth liver margin is suggestive of malignancy of the gall-bladder; when the liver becomes secondarily involved there is an irregular nodular mass. In addition to the physical findings, x-ray study demonstrates a suggestive shadow, although, because of occlusion of the cystic duct, the dye may not enter the gall-bladder and give the usual visualization. The calculi may or may not be demonstrated.

Treatment. Surgical treatment alone offers relief. Cholecystectomy is of value if the disease is confined to the gall-bladder; when the malignant process has invaded the liver margin adjacent, excision of the involved area is indicated. If the ducts are involved, drainage or anastomoses may be attempted, but little can be accomplished. If pylorus is obstructed, gastro-enterostomy may be attempted. In our last case, the gall-bladder tumor mass, together with an extensive margin of invaded liver structure, was excised. This patient lived 3½ months following operation. Operative mortality is high. In 19 cases cited by Shelley, 14 died within a few weeks. One lived 6 years. Average duration of life is less than a year. Although malignancy of the gall-bladder is relatively a rare disease, it is, of course, a serious malady which in the majority of instances follows a long pre-existing cholelithiasis, with inflammation of the gall-bladder. Since the existence of this malignancy can not always be determined clinically with certainty, a radical operation with expectation of a cure is already excluded when it is recognized. Further, as the danger of recurrence is great when radical operation is carried out early, it logically follows that the chronically inflamed gall-bladder with stones, should be removed before the development of malignant degeneration. This is particularly true in those cases with a family history of malignancy.

State Society Activities

NOMINATING COMMITTEE

The publication of this list of the members of the Nominating Committee in the March issue of the Journal of the Medical Society of New Jersey is made mandatory by the Constitution and By-Laws.

J. B. MORRISON, M.D.,
Secretary.

COUNTY	DELEGATE	ALTERNATE
Atlantic	Walt P. Conaway, 1723 Pacific Ave., Atlantic City	
Bergen	A. Liva, 5 Pangborn Pl., Hackensack	
Burlington	Harry L. Rogers, Riverton	E. W. Rodman, Beverly
Camden	Thomas B. Lee, 622 Cooper St., Camden	
Cape May	Clarence W. Way, Sea Island City	
Cumberland	H. G. Miller, Millville	
Essex	A. Stahl, Newark	A. C. Zehnder, Newark
Gloucester	R. K. Hollinshead, Westville	C. I. Ulmer, Gibbstown
Hudson	Joseph F. Londrigan, 438 Washington St., Hoboken	H. Alexander, Hoboken
Hunterdon	A. H. Coleman, Clinton	S. B. English, Glen Gardner
Mercer	Harry R. North, 160 W. State St., Camden	D. L. Haggerty, Trenton
Middlesex	Joseph S. Marks, Woodbridge	
Monmouth	William G. Herrmann, Asbury Park	
Morris	Bernard G. McMahon, Morristown	
Ocean	Eugene Herbener, Lakewood	
Passaic	J. V. Bergin, Paterson	J. H. Carlisle, Passaic
Salem	R. M. A. Davis, Salem	
Somerset	D. S. Renner, Skillman	
Sussex	F. P. Wilbur, Franklin	
Union	Stephen T. Quinn, 1143 E. Jersey St., Elizabeth	
Warren	Lawrence Bloom, Phillipsburg	

Chairman of Committee and representative of the Fellows,
A. Haines Lippincott, 406 Cooper St., Camden

WELFARE COMMITTEE

A meeting of the Welfare Committee of the Medical Society of New Jersey was held on the afternoon of Sunday, February 11, 1934, in the Stacy-Trent Hotel, Trenton, with the President, Dr. Frederic J. Quigley, presiding, and thirty members present. Dr. Thomas K. Lewis acted as Secretary in the absence of Dr. LeRoy A. Wilkes, who was in Milwaukee as the guest of the Wisconsin Medical Society, he having been invited to explain the public health work of the Medical Society of New Jersey.

Dr. Quigley introduced Dr. Watson B. Morris, of Millburn, who had recently been appointed a member of the Committee in the place of Dr. Charles H. Schlichter who had resigned on account of ill health.

Workmen's Compensation—Dr. David A. Kraker, Chairman of the Sub-Committee on the Workmen's Compensation Act, gave a report of which the following is an abstract:

"The Committee held a meeting with the Medical Directors' Committee of the National Bureau of Casualty and Surety

Underwriters and two meetings with its sub-committee. While many details were discussed regarding the relations of physicians to compensation insurance, no decisions were reached.

"The Committee also conferred with the Investigating Committee on Compensation Law, and has held several meetings. It has also made visits to the Compensation Courts and Rehabilitation Clinic, and has made recommendations and presented them to the Commissioner of Labor and to the Committee on Legislation."

Dr. Andrew McBride, formerly Commissioner of Labor, and now Chairman of the committee on investigate Workmen's Compensation, stated that the members of the Legislature were favorably impressed with the recommendation of the physicians representing the Welfare Committee. He said that the committee had put their recommendations in proper form for presentation to the Legislature and Governor Moore.

Dr. Quigley suggested that Dr. Kraker get

information regarding the actions taken in New York State. (An eight-page report of the Physician's Committee on Workmen's Compensation, appointed by Governor Herbert H. Lehman, was published in the New York State Journal of Medicine of January 15, 1934, page 74—*Editor's note.*)

Legislation—Dr. Samuel Alexander, Chairman of the Committee on Uniform Medical Practice Act, reported that his committee has met with a committee of the New Jersey State Board of Medical Examiners and had not been able to draw up a bill requiring a single standard of qualifications for all who are engaged in the practice of the healing art. However, the committee presented a bill which it had drawn up for the purpose of restricting the display of the title of "Doctor" by those who were not Doctors of Medicine, or of Dental Surgery, or of Veterinary Surgery.

Dr. D. Leo Haggerty, of Trenton, Chairman of the Sub-Committee on Legislation, described several medical bills which the Legislature is now considering.

Assembly Bill 28 would restrain hospitals receiving public funds from charging anything for services to patients. It was the opinion of the Welfare Committee that a small fee might be charged to each patient as an admission fee, to be used principally for social service investigations. It was further suggested that the Legislative Committee should confer with the Hospital Association before deciding on the features of the bill.

Assembly Bill 73 proposes to extend the field of the practice of osteopaths. While the present law forbids them to do surgery or use drugs, the new bill would permit them to do almost any kind of operation except cesarean section, and to use water, specific food, air, heat, cold, light, anesthetics, antiseptics, antitoxin, germicides, parasitocides, anodynes, and narcotics for the relief of pain.

The Welfare Committee discussed methods by which the physicians should oppose this bill. It was the consensus of opinion that the members of the Legislative Committees of the several counties should inform their legislators of the dangers to public health that would follow the removal of any of the restrictions regarding diagnoses and treatments by persons who have not had adequate medical training.

Assembly Bill 132 would correct a serious situation in which the Emergency Relief Administration is forbidden to pay any physician who is now receiving money from any branch of the government. The interpretation of this law is that a doctor serving as school physi-

cian could not receive pay for treating patients under the E. R. A. This restriction is now working a hardship on the people in a rural community which has only one doctor and he has to perform all kinds of medical service and be health officer and school physician. If he could not treat E. R. A. cases, the poor would have to travel miles in order to reach a physician recognized by the E. R. A. This bill is sponsored by Dr. Walter T. Gutowski, Assemblyman from Essex County.

Report on Public Health—Dr. Stanley H. Nichols, Chairman of the Committee on Public Health, gave a report, of which the following is a summary:

REPORT OF PUBLIC HEALTH COMMITTEE

By Dr. Stanley H. Nichols, Chairman

The Public Health Committee has considered several matters of state-wide interest since the last report to the Welfare Committee.

(1) *Blood Donors*—The Committee has considered the control of blood donors from three aspects.

(a) It has consulted the State Department of Health regarding methods of approaching the problem, and the attitudes of various groups toward the control.

(b) Information has been sought from other states regarding legislation and procedures on the subject.

(c) The committee voted to call a conference of surgeons and pathologists to give their views in the near future.

The Welfare Committee voted its approval of the proposed conference.

(2) *Prescriptions for Medicinal Alcohol*. The Public Health Committee voted to recommend that the State Alcoholic Beverage Control Act be amended to provide for the dispensing of medicinal liquor of U. S. P. standard on prescription through pharmacists so that whiskey and brandy of known strength and purity can be available at all hours for physicians' use. It is the feeling of the committee that the present sources of liquor do not provide a satisfactory supply, nor one which is available at all hours of the day and night.

The Welfare Committee voted to postpone action since the general plans of control are in an early stage of development.

(3) *The Pure Food and Drug Bill*—Dr. H. A. Brodtkin, 365 Osborn Terrace, Newark, a member of the Essex County Medical Society,

had presented arguments for the national Tugwell-Copeland Bill before the Public Health Committee, reporting that the bill had been endorsed by the Essex County Medical Society, the American Medical Association, and the Bureau of Food and Drugs of the New Jersey Department of Health.

The essential features of the Tugwell-Copeland Bill now before the Federal Congress amends the Pure Food and Drug Act of 1907 by extending its provisions along the following lines:

(a) Extending the definition of what constitutes a drug so that it includes cosmetics.

(b) The prohibition against misbranding shall be extended so as to include any false, exaggerated, or misleading claims whether they appear on the trade package, or in advertisements of any kind, or over the radio. The present law applies only to statements appearing on the trade package; the manufacturers or dealers can make every sort of claim in an advertisement with impunity.

(c) The trade package of every patent medicine shall show every ingredient used in the preparation.

(d) No advertisements are permitted for cures of such conditions as albuminuria, appendicitis, arteriosclerosis, bone diseases, blood poisoning, cancer, cataract, gall-stones, nephritis, prostate gland disorders, impotence, and similar conditions.

The bill is designed to institute standards of honesty in the food and drug and cosmetic industries. The major opposition to the bill arises from the fear of a possible unwarranted intrusion upon business rights if the power of control is centralized in the Federal Department of Agriculture.

The Welfare Committee endorsed the recommendations of the Public Health Committee and voted:

(a) To approve the Tugwell-Copeland Bill and to publish its essential points in the Journal.

(b) To request the County Medical Societies to approve the bill and to advise their Senators and Congressmen of the benefits to public health which will result from the enactment of the bill.

(c) To give out news items to the newspapers so as to inform the people of the action of the medical profession.

(4) *Diphtheria Immunization.* Dr. Nichols began his report on this topic as follows:

"The most important activity of our Committee might be well called the Doc-

tors' Practice Recovery Program, namely, the recapture and coördination of all of the health activities in each County under the supervision of the County Medical Society, and the return to the doctors' offices of all of the branches of preventive medicine, beginning with diphtheria immunization. May I again repeat and emphasize that political and social groups are now standing ready to take over the whole field of public health, if we health professionals in New Jersey fail to take advantage of this opportunity and possess the land for each County Medical Society in New Jersey."

Dr. Nichols reported that the diphtheria immunizations were being given by doctors in their offices in the well populated counties, but the rural physicians were adopting the plan more slowly owing to a lesser degree of organization of the health forces. The State Department of Health is actively promoting the immunizations in the rural districts through Mr. William MacDonald, Chief of the Bureau of Local Health Administration and the District State Health Officers and with the active coöperation of the district Councilors of the State Medical Society.

The Public Health Committee made the following recommendation which was adopted by the Public Welfare Committee:

"That Public Health Nurses supply lists of names and addresses of physicians in the community in which they work who offer diphtheria immunization to all persons in their Public Health Hour at \$1 per injection. Since certain physicians prefer to conduct this work in their regular office hours at the same charge as in the Public Health Hour, this fact should be noted in such cases so that the nurses may inform those who may wish to be immunized by these physicians."

Dr. Nichols discussed the efforts that were being made to secure an appropriation of \$10,000 for the purpose of supplying immunizing toxoid free to physicians who were coöperating with the State Department of Health and the State Medical Society in the immunizing campaign.

Dr. Quigley reported that the State House Commission has been requested to provide \$10,000 for immunizations as approved by the State Board of Health, and that Health Commissioner Mahaffey, Dr. LeRoy A. Wilkes and himself had interviewed Governor A. Harry Moore who approved the project.

LEROY A. WILKES,
Executive Secretary.

FIFTH COUNCILOR DISTRICT

A joint meeting of the Public Health Committees in Councilor District Five and the Cape May County Medical Society was held on Saturday, February 23, 1934, at the Hotel Bellevue, Cape May Court House. This Councilor District is composed of the Counties of Cape May, Cumberland, Atlantic, Gloucester, and Salem.

This was a luncheon meeting beginning at one o'clock. President Warren D. Robbins of the Cape May County Medical Society presided. There were twenty-eight physicians present including representatives from each of the Public Health Committees in the five component county societies of the district.

Dr. I. W. Knight, of Gloucester County, the newly elected member of the State Public Health Committee, was introduced. Dr. Knight is assigned by the State Public Health Committee as Health Activities Advisor in this councilor district.

On the committees of the State Medical Society are representative members from all parts of the state. The contributions of those from the rural areas are especially valuable in conferences of the Public Health Committee; and Dr. Knight is a most welcome addition to that Committee of the State Society. The officers of the State Medical Society visit the component societies as often as possible, but they must rely to a large extent on the District Councilors and the Executive Secretary to learn the needs and satisfactions of the members, especially those of rural areas.

Dr. Aldrich C. Crowe, of Ocean City, District Councilor, and Dr. LeRoy A. Wilkes, Executive Secretary of the Medical Society of New Jersey, led the discussions. The topics discussed were the aims and procedures in:

- (1) Legislative work;
- (2) Emergency Relief Administration Project;
- (3) Civil Works Administration Project;
- (4) Public Health Project.

Dr. Ida M. Friedland, of Woodbine, Cape May County, brought up some important points regarding the operation of the Emergency Relief Administration in rural communities. Dr. Friedland related her experience with a maternity patient who was in labor when she was called for the first time. The doctor was excluded from receiving pay from the E. R. A. on two grounds:

- (1) She had not given the three months' pre-natal examinations and treatment which are required by the E. R. A.
- (2) She was the school physician—the

only doctor available in the community—and was, therefore, already technically receiving a salary from the municipality and therefore ineligible to receive pay from the E. R. A. There was no hospital to which the patient could be taken and no other physician for miles around. The doctor was faced with the alternative of either responding to a call of mercy, or refusing to attend the patient at all and thereby subjecting not only herself but her medical colleagues to putting money above a call to service. She did what all other doctors do under the circumstances, she gave her services without the expectation of fee or reward.

While the community was sympathetic in praise of the doctor, the people also commended the local administrator for being "careful and economical". This was an example of injustice worked by the enforcement of "rules and regulations", which should be humane and flexible.

Dr. Wilkes suggested that a possible solution of the problem was to have called the case an emergency in which immediate skilled attention was required, for the E. R. Administrators are authorized to suspend rules in emergencies. There was a question of whether or not a normal confinement could technically be called an emergency. The common sentiment of the people of New Jersey is that any child birth is an emergency in which the mother is entitled to medical attention as a matter of human kindness.

Cases like this are arguments for the liberal interpretation of rules and laws governing relief. However, there is a type of administrator whose carefulness to follow rules leads him to violate the simplest dictate of the Golden Rule.

The conditions which prevail in rural areas can be understood and appreciated only by those who have a wide experience under these conditions. Public Health protection can be effective only when the ways employed are designed to meet the particular needs of the people. A knowledge of the psychology, the culture, and the traditions of the people of rural areas is as important as the technical knowledge of the doctor or health officer.

Mr. Daniel C. Bowen, District State Health Officer, was present by invitation, and spoke on the proposed cooperative effort in diphtheria immunization approved by the State Department of Health and the Medical Society of New Jersey.

The meeting adjourned at 5 o'clock.

LEROY A. WILKES,
Executive Secretary.

County Society Reports

ATLANTIC COUNTY

Robert A. Kilduffe, Reporter

Meeting of January 12, 1934

The regular meeting of the *Atlantic County Medical Society* was held Friday, January 12, 1934, at Haddon Hall, Dr. David B. Allman presiding. There were 65 members and guests present.

The society adopted memorials of two deceased members, Drs. Thomas G. Dunlap and George John Muellerschoen. It also passed a motion of sympathy with Dr. Alfred W. Westney on the death of his son, Alfred W. Westney, Jr.

Three amendments to the By-Laws were proposed. Number one related to the appointment of a nominating committee at the meeting preceding the annual election. Number two related to the monthly meetings and the manner of conducting them; and number three outlined an order of business.

A motion was carried to extend from the Society an invitation to both the American Medical Association and the Canadian Medical Association to meet in Atlantic City, in 1935.

Dr. H. S. Head was accepted as a member on his transfer from the Philadelphia County Medical Society.

E. R. A.—Mr. Spurgeon Cross, Deputy County Director of the Emergency Relief Administration, requested the Society to sponsor a bed-side service of seven nurses to be selected from the unemployed nurses of Atlantic City. This service was formerly rendered by the visiting nurses and other agencies, but was discontinued owing to the depression. The request was referred to the Public Health Committee with full power to act.

County Sanatorium—The Medical Advisory Committee reported that the Emergency Relief authorization now covered three visits instead of one, after which a new authorization must be secured. A new prescription blank is now available which will facilitate the filling of prescriptions during the hours when the E. R. A. Headquarters are closed.

A motion was passed that the President appoint a committee to wait upon the Board of Freeholders and to urge upon them the necessity of more adequate quarters for the County Tuberculosis Sanitarium, the present capacity of which is 48, whereas, it is estimated that 200 beds should be provided in order to give adequate and early treatment to the increasing numbers of sufferers from this disease. It was suggested that Federal funds be requested for the accomplishment of this project.

Dr. Allman appointed the following to this Committee: Dr. E. H. Harvey, Chairman, Dr. Myrtle Frank and Dr. S. L. Salasin.

Scientific Program—The Scientific Program was on the subject of the Public Relations of Medicine. Dr. Peter E. Maras, President of the Jersey City Medical Society gave a paper on "Public Health Activities and Their Relations to Organized Medicine."

Dr. Spencer T. Snedecor, Chairman, Medical Relief Committee of the State Society, spoke on "Providing Medical Care for the Indigent", in which he reviewed the work done in the several societies.

Dr. Stanley H. Nichols, Asbury Park, Chairman of the Committee on Public Health of the Medical Society of New Jersey, spoke on "The Public Health Plan of the State Medical Society and How It Can Be Used in Atlantic County". An abstract of his paper follows:

THE PUBLIC HEALTH PLAN OF THE MEDICAL SOCIETY OF NEW JERSEY, AND HOW IT CAN BE USED IN ATLANTIC CITY

By Stanley H. Nichols, M.D.,
Asbury Park, N. J.

Chairman of the Public Health Committee of the Medical Society of New Jersey

The question—is medical care adequate for *all* the American people?—is a challenge issued by social welfare leaders. The medical profession answers that better medical care is readily possible, and to provide it has been the constant aim of the practicing physician for centuries. Physicians are coming to realize that in addition to their burden of individual curative practice, they must assume the leadership in solving *all* the problems of community health; or else other groups,—social, welfare, or political,—will attempt their solution without regard to the doctors.

Physicians are not the only workers in the field of health; but there are in fact at least seven groups in New Jersey:

- (1) Physicians
- (2) Dentists
- (3) Pharmacists
- (4) Health Officers
- (5) Nurses
- (6) Hospitals
- (7) Social Welfare Workers

We believe that the very best method of providing adequate medical care for all the people is that in which all these seven groups join their forces, each group supplying the essential service for which it is best fitted.

The Medical Society of New Jersey has been organizing all of the state's professional workers for *team-work* in the services of child hygiene and public health. While the *quarter-back* of this health team may be the trained health administrator, the *full-back* must be the family physician.

It is only by placing the organized medical profession in the very forefront of organized responsibility for public health measures, that permanent success will come along the line of medical participation and teamwork. We admit that the physicians of the past, as a group, were individualists. Our task of the present is to help them to become more public-health-minded also. The Medical Society of New Jersey is in a position to lead the way in the United States in this respect. Social-

ized medicine, health, insurance, political medicine, welfare medicine, and various other brands of social soothing syrups confront health workers on every hand as a panacea for all health ills; but the seven groups of health workers, can get together and deliver medical care and health to all people by *evolution* better than by *revolution*. This is what the Medical Society of New Jersey, with the help of other health organizations, proposes to attempt.

The State Society took up the subject of teamwork among the several organizations in 1931 and appointed a Public Health Committee composed of physicians, but with a Sub-Committee composed of the executive leaders of all the State agencies dealing with health, headed by Dr. J. Lynn Mahaffey, Commissioner of Health.

The program of the Committee for 1932 included the following objectives:

(1) The publication of "Principles of Working Relationships" which were adopted by the State Medical Society.

(2) The creation of a public health committee in each of the twenty-one county societies.

(3) The assignment of members of the State Committee to Councilor Districts as advisors of the Committees of the County Societies.

The 1933 plan presented by the committee and adopted by the State Medical Society in June, 1933, has two specific objectives.

(1) Diphtheria immunization of children between the ages of six months and six years, preferably before the age of two.

(2) Health supervision of the pre-school child by the family physician by means of a semi-annual examination on the New Jersey Medical Society Pre-school Record Form (to be supplied by the Committee). This examination is to be followed by recommendations for active measures for health improvement in the child, and the subsequent general health supervision of the pre-school child by his family physician.

The essential working agency for the definite accomplishment of these two objectives is the Medical Society, whose public health committee shall form an intimate contact with the other six groups of health professionals, beginning with the health officers. The method used to accomplish this line-up will naturally vary in the different counties in the State. For instance, in my own county, Monmouth, it has been accomplished by the Public Health Committee appointing a *sub-committee* to consist of the accredited representatives of the health officers, nurses, hospitals, dentists, pharmacists and medical social service workers; and as *auxiliary* members of that sub-committee, public officials and representatives of all health and welfare agencies operating within the county. This group, under the direction of the County Society Public Health Committee, is undertaking the diphtheria immunization of all pre-school children in Monmouth County.

The Welfare Committee of the State Society has endorsed the plan of establishing a trial period of one year during which each physician member of the State Medical Society shall establish, somewhat along the lines of the Vaughan plan

in Detroit, a public health hour in his own office at intervals determined by him, during which hour he will offer diphtheria immunization to all persons able to pay at one dollar per injection.

The members of the State Committee and its Sub-Committee are ready to advise the committee of Atlantic County, or of any other county society, in regard to the adoption of any phase of public health work.

Meeting of February 9, 1934

The regular monthly meeting of the *Atlantic County Medical Society* was held Friday, February 9, in the Benjamin West Room of Haddon Hall, Dr. D. B. Allman presiding. Forty-eight members and guests were present.

Dr. E. H. Harvey, Chairman of the Public Health Committee, reported that 35 members had expressed their willingness to carry out the diphtheria immunization plan of the State Society.

Dr. Allman stated that the matter of the new tuberculosis hospital had been brought to the attention of the Board of Chosen Freeholders at their last meeting, and that various civic organizations had voted in favor of this project. Dr. Carrington announced that the Chamber of Commerce had unanimously endorsed it at the last meeting.

Dr. John S. Irvin, reporting for the Medical Advisory Committee, said that there was no limit to the number of visits a physician could make under the Emergency Relief Administration, but that after ten visits a new investigation had to be made. Dr. Irvin also stated that the druggists were complaining that many prescriptions being written contain proprietaries. Many of these can only be filled at a loss to the pharmacist. Prescriptions should be written only for U.S.P., or N.F. drugs; otherwise the pharmacist is authorized to refuse to fill them. Exceptions may be taken up directly with the E. R. A.

The State E. R. A. has made a new rule that all physicians doing this work must keep a list of all cases treated including the diagnosis and number of calls made. At the end of each month this list must be sent to the Medical Advisory Committee. No bills will be paid until these lists have been approved by this Committee.

A letter from Dr. Quigley, State President, to Mrs. S. L. Salasin, Chairman of the Entertainment Committee of the Auxiliary, to the State Society regarding a dinner and dance to be held in June at the State Society meeting here, was referred to the Entertainment Committee for action in conjunction with the Auxiliary.

The Amendments to the Constitution and By-Laws as read at the January meeting were unanimously accepted.

Dr. W. J. Carrington stated that the Post-Graduate Course selected was six lectures on "The Clinical Interpretation of Neurological Symptoms", by Dr. E. A. Spiegel, to be held every Wednesday at 8.30 p. m. in the Pacific Avenue Nurses Home beginning February 28; and that an enrollment of 25 men was necessary, and the cost would be \$10 each.

Dr. Irvin stated that only 55 per cent of the

members had paid their dues up to the date of the meeting, and urged prompt payment so that the entire membership can appear in the official list of the State Society. It was decided to continue the membership in the Chamber of Commerce and the notice in the Philadelphia Weekly Roster and Medical Digest, and to ascertain how many of the members are now receiving a copy of the Roster.

Dr. S. Barbash was appointed sole member of a Publicity Committee to bring the work of the Society before the press in the proper manner.

Dr. E. H. Harvey reported for the Public Health Committee that the Powers X-Ray Products, Inc., wished to make a contract to take x-rays of the chests of all the pupils in the public schools of Atlantic County. The Powers Corporation sells service, bringing an x-ray machine and taking the pictures on a long roll of paper, and then developing them in their own laboratory. The cost varies from seventy-five cents to one dollar for each pupil, and from 500 to 800 pictures can be taken in a day.

Dr. Harvey opposed the plan, giving as his reasons the hurried nature of the examinations, the uncertainty of the diagnosis; and the incompleteness of the data regarding each pupil; and the probability of exciting a nervous apprehension in mild cases.

The following resolution was passed unanimously:

"Your Committee on Public Health is opposed to contractual and commercial mass diagnosis by lay, health or medical men, and minds representing firms who primarily have something to sell, and to individuals, groups or organizations, lay or otherwise, who under the guise of altruism are seeking opportunities for self-aggrandizement, either mercenary or simply laudatory or commendable, thus displacing the regular licensed physician in his work and usurping his rights and privileges. Therefore, be it

"Resolved, that the Atlantic County Medical Society discourage and look with disfavor upon any and all attempts to introduce mass-diagnosis for pulmonary tuberculosis in the Community."

Dr. A. G. Merendino reported for the Broadcasting Committee that Dr. S. Barbash will broadcast on Friday, February 16, on the work of the Public Health Committee of Atlantic County; and Dr. Andrews M. Smith on February 23, on the work of the Emergency Relief Association.

The Scientific Program was presented by Dr. Louis H. Clerf on "The Diagnosis and Treatment of Bronchiectasis"; Dr. John B. Flick on "Surgery in the Treatment of Bronchiectasis" and Dr. John T. Farrell, Jr., on "Bronchiectasis, Its Diagnosis and Treatment and Roentgenologic Aspects".

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held February 13 at Holy Name Hospital, Teaneck, N. J., and was called to order by Dr. A. Liva, President.

The minutes of the Executive Committee report, as printed in the February Bulletin of the County, were mentioned by Mr. Whitehead. Mr. Whitehead added a paragraph that the Bergen County Medical Society sponsor the formation of a Health Service Committee which was to be composed of the existing health agency groups with representation from:

- (1) Bergen County Medical Society,
- (2) Dental Society,
- (3) Hospitals,
- (4) Nursing Services,
- (5) Public Health and Sanitary Association,
- (6) Pharmaceutical Society,
- (7) Social Service,
- (8) P.-T. A.
- (9) Superintendent of Schools,
- (10) Editors of the Press.

This report was approved.

The Secretary stated that Dr. Stanley Nichols, Chairman of the Public Health Committee of the State Medical Society, had approved our public health program.

Dr. David Corn reported that the post-graduate course given by the State Medical Society and Rutgers University had been completed. He mentioned that a course in surgery was to commence this week.

The following new members were elected:

To Regular Membership: Samuel Yachnin, Lyndhurst.

From Junior to Regular Membership: Abraham Goldfarb, Rutherford; B. J. Ellmers, New Milford; Isador Gittelsohn, River Edge; A. M. DeSanto, Hackensack.

To Junior Membership: V. A. Lamberto, Lyndhurst; J. F. Benjamin, Ridgewood.

New applications for membership were received from: Dr. Walter L. Liefeld, of Passaic, who is transferring from New Castle County Medical Society in Delaware; and Dr. Louis M. Sosnow, of Hillsdale.

Dr. E. P. Essertier, Chairman of the Welfare Committee, reported his findings in regard to the contemplated raise, from residence to business rates in electricity, for the doctors who use more than two rooms in their homes exclusively for gainful or business purposes. Dr. Essertier moved that this matter be referred to the Welfare Committee of the State Medical Society, urging it to ask for a public hearing before the Public Utilities Commission. This motion was passed.

Dr. S. T. Snedecor then moved that the Bergen County Medical Society send a resolution to the State Senators and Representatives asking for indorsement of the amendment to Senate Bill No. 43. The bill, which is the Emergency Relief Act, at the present time excludes medical inspectors of schools, board of health doctors, and others, from receiving payment for care of E. R. A. cases. The amendment is to rectify this error. Motion was passed.

Dr. S. Alexander moved that the Secretary be instructed to write a letter to the State Assemblymen asking them to oppose Senate Bill S-73, whose purpose was to remove the restrictions on osteopaths. This was passed.

The Executive Secretary called attention to the new emergency relief rulings, as printed in the Bulletin; and to the memorandum in regard to the compensation for Civil Works Administration cases.

Mr. W. Blanksteen, representing the National Casualty Company, spoke on the New Jersey Medical Society group, accident, and health insurance, urging members to take advantage of it.

The meeting was then turned over to Dr. G. M. Levitas, Chairman of the Scientific Committee, who introduced Dr. Arthur M. Fishberg, Associate Physician to the Beth Israel Hospital, an Adjunct Physician to Mt. Sinai Hospital, New York, and author of the book "Hypertension and Nephritis". Dr. Fishberg gave a splendid outline of the presumptive causes, diagnosis, and sequelae of essential hypertension. He stressed particularly the minimizing of the importance of essential hypertension to the unfortunate patient.

The meeting adjourned for refreshments.

ESSEX COUNTY

Earl Le Roy Wood, Reporter

Special Meeting

January 19, 1934

A special meeting of the *Essex County Medical Society* was held Friday evening, January 19, 1934, at the Academy of Medicine, Newark, to hear Dr. Bela Schick. This was arranged by the Post-Graduate Instruction Committee preparatory to undertaking the diphtheria immunization program. Dr. Schick, describing the general fundamental theories of the Schick Test and diphtheria immunization, gave many specific practical suggestions.

Schick Test—An inflammatory reaction to the Schick Test is a positive reaction; no reaction is a negative one. Although there are some pseudo-reactions or allergic reactions to some other protein substance in the toxin, it is probably safest when in doubt to consider any reaction a positive one. Care should be exercised to protect the toxin from light. Use a reliable toxin for the test, which may be read from the fifth to the eighth day though Dr. Schick and others read the test at 48 hours. Pseudo reactions are rare during the pre-school age. Eighty-five per cent of new-born infants have an immunity which is inherited, but is lost during the first six months of life. At one year of age ninety per cent of infants are susceptible. Active immunization is indicated between the ages of six and twelve months. From age one with ninety per cent of babies susceptible, the immunity rises to eighty-five per cent immune at age seventeen. During school age fifty to sixty per cent are spontaneously immune. The Schick Test is reliable.

Considering the production of immunity by injection of either toxin-antitoxin solution or the toxoid, Dr. Schick said that while the latter produced more local reaction it was a quicker producer of immunity. He advised caution in injecting the tuberculous with toxoid, but recommended the toxin-antitoxin for children of school age, reserving the toxoid for the pre-school and adult ages.

As to the time of year for immunization of infants, June or July allows a safe period for the immunity to develop before the diphtheria season is encountered.

Medical Relief Plan—The Newark Administrator has definitely agreed to put the E. R. A. plan into effect in Newark, and it should soon be in operation. The medical profession however will have to continue the present clinics and carry the 1929 clinic load. However, if the excess of the 1933 clinic load is raised from the shoulders, and only the 1929 load remains, the relief will be sizeable as will appear from the Newark City Dispensary figures for the number of treatments:

In 1929 about 90,000.

In 1933 about 280,000.

A two-thirds reduction of the clinic load will certainly be welcomed by the medical profession.

Regular Meeting

February 8, 1934

The Society held a regular meeting in the Academy of Medicine, Newark, at 8:45 p. m. on Thursday, February 8, 1934. There were 250 members present, and an immense amount of business was transacted. Twelve regular and five associate members were elected. The Society adjourned at 12:30 a. m.

Under Report of Council, a resolution was adopted that a letter be sent to the Board of Trustees of the State Society asking that no member be considered delinquent whose dues are paid by April first instead of February first.

A motion recommending that Dr. C. B. Griffith be transferred to honorary membership was unanimously approved.

Dr. Teeter, Chairman of the Committee to Study Heart Problems, reported a plan of organization of *The Heart Committee of the Essex County Medical Society*, outlining its purpose, membership, committees, and order of business at meetings. The report included survey of the leading importance of heart diseases, statistics on mortality, incidence of complicating diseases, prophylaxis in children and adults, institutional facilities, periodic health examinations, rehabilitation, development of further organization through the state and affiliation with the American Heart Association, educational publicity, research work, heart clinics, and social service.

For the Medical Relief Committee, Dr. Hawkes reported the present status of the E. R. A., which is now ready to act, and for which the administration will have ready plans and paraphernalia for functioning throughout the county. Physicians who choose will be registered as prepared for such services. Questions regarding the operation of this relief program; who are entitled to service; how the authorization will be secured from the administration; how bills for service will be paid, were satisfactorily answered. Concluding the report, Dr. Hawkes moved a vote of thanks by the Society to Dr. Quigley, President of the State Society, with appreciation for his ardent and valuable coöperation in bringing these negotiations to a successful conclusion, which was passed with zest.

Dr. W. T. Gutowski, a member of the State Legislature, asked for the reaction of the County Society on an amendment to the Emergency Relief Law introduced by him in the Assembly, removing the exclusion of doctors receiving salaries for public medical work from additional pay under E. R. A. The Amendment allows all physicians to participate in taking care of indigent patients. To this end he suggested the following resolutions: "That the Essex County Medical Society endorse an amendment to the Emergency Relief Act, Chapter 394, Law of 1931, the Amendment exempting all physicians from being included in enforcement of that act." On motion by Dr. Willner, seconded by several, the resolution was unanimously passed.

In addition to the work of the E. R. A., Dr. Hawkes reported the committee is now charged with the responsibility for the medical administration of the C. W. A. in regard to the treatment of occupational injuries and diseases. Physicians will be registered as prepared for such services, as they are now under the Workman's Compensation Law. A recommendation of the Council, being duly seconded, was approved that "The Essex County Medical Society delegate to its Medical Advisory Committee the same administrative and disciplinary powers under the C. W. A. as already delegated to this committee under the E. R. A."

For the Membership Committee, Dr. Murray, for Dr. Rathgeber, reported success in new members secured. More than 50 had been secured since October, 1933. The Treasurer reports 757 members in good standing today.

For the Committee on Illegal Practitioners, Dr. Fort reported that a number of cases had been sent to the State Board, and some results were obtained.

Dr. Sprague announced receipt of a promise from the Woman's Auxiliary of a contribution of \$500 to the Permanent Fund for the Economic Relief of members in distress. On motion by Dr. Frank Devlin, the Secretary was instructed to send a letter of thanks to the Auxiliary.

For the Welfare Committee, Dr. W. H. Areson reported that investigation of compensation cases is now before the Legislative Committee, recommending:

(1) That the carrier discontinue the treatment of compensation injuries or occupational diseases and substitute a cooperative medical supervision.

(2) That the employee shall have the right to select his own physician.

(3) That as most of the problems are of a medical nature, the adjudication should be determined by medical men, rather than by lawyers as done now.

(4) That at the primary hearing, presided over by the Deputy Commissioner, all testimony to be stenographically recorded.

(5) Co-incident with the primary hearing, an examination by the State Examining Physician, who shall determine the disability involved, this to constitute the medical evidence stenographically recorded at the primary hearing.

(6) Upon a dispute from the findings of the State Examining Physician, an appeal may be taken

to the Medical Board of Referees whose report will constitute the medical evidence in the case, and will be forwarded to the Commissioner of Labor.

(7) The State Physicians are to be appointed by the Commissioner of Labor upon the recommendation of the State Medical Society of physicians licensed to practice in New Jersey. They shall be compensated, and be full-time men. The members of the Medical Board of Referees are to be appointed by the Commissioner of Labor, upon the same recommendation as for the appointment of State Physician, and they shall be adequately compensated for their full-time work. This Board shall consist of five men, at least three of whom shall be present at each hearing, and to this Board shall be referred all medical matters in dispute. This Board, as well as the State Examining Physician shall render an annual report to the Commissioner of Labor, such report to be published and distributed to the medical and legal professions and all others concerned.

On motion duly seconded the recommendations were approved.

For the Committee on Post-Graduate Instruction, Dr. Satchwell reported arrangements were being made for post-graduate courses at an initial fee of \$15, with low additional fees to include all other courses.

For the Public Relations Committee, Section on Economics, Dr. Lowrey reported as follows: The approval of the plan of Medical Relief by Dr. Hawkes' Committee, making an additional recommendation that a physician be assigned to each relief station to inspect or supervise the records of the work done by the physicians, to prevent the possibility of some local agent favoring any one physician. Also that hospital clinics be for the indigent only, and pay clinics be abolished.

On the Problem of Commercial X-Ray Laboratories the Committee reported progress.

On Salaries of Physicians holding public medical positions, the recommendation was made that those in the lower brackets be increased.

On Optometry the recommendation was that the law be changed so as to forbid the use of the title of doctor by those not licensed to practice medicine.

On a Lien Law to cover physicians, the committee recommended that the amendment forwarded to the State Welfare Committee be approved.

On Medico-Legal Testimony in court, the subject is still under consideration with a request that the legal bar association appoint a committee for conference with us.

On Case-Lifting, the recommendation was that the already adopted policy be reiterated, and that the Society approve the resolution adopted by the Council suggesting action by every hospital and medical staff in the county.

On Practice by Corporations, it was recommended that an effort be made to restrain such practice by injunction.

On Foreign Graduates in Medicine, an interesting table had been painstakingly compiled showing foreign graduates are less than 10 per cent of the total, and of those nearly one-quarter were born in the United States.

On Contract Practice, the policy adopted has been against it, but the question "What is unethical?" is still being debated.

On a Finance and Collection Agency, the sub-committee is not yet ready to report in their aims to adopt some plan to assist the doctor in reducing his losses from overdue accounts.

On Fact-Finding, the committee suggests a permanent Committee on Economics on a rotating basis of 21 members, seven appointed annually for a three-year term.

For the Public Relations Committee, Section on Hospitals, Dr. Areson reported a very comprehensive and concise review of all the problems outlined for the committee's work, and made recommendations on each for improving the social service organizations in the hospitals. It was recommended that salaried Social Workers be employed to work with a committee from the medical staff.

On the Flat Rate Practice common in hospitals, the recommendation was approved that the matter be given further consideration with view to providing remuneration for the doctors.

On Hospital Health Insurance, the recommendation of disapproval was adopted.

On Revocation of a Doctor's License, the recommendation was approved that one guilty of unethical conduct may have his license revoked upon recommendation of the Ethics Committee. On representation of the medical staff on a Hospital Board, the recommendation was approved that at least one such medical representative on the Ethical Committee be recommended by the staff.

Upon Illegal Practitioners, recommendation was approved that an offender incur a term in jail, not simply a fine.

On Expert Testimony, recommendation was approved that the Ethics Committee be instructed to investigate any case of abuse of unethical testimony.

On the subject of Payment for Medical Services rendered, the recommendation was approved (a) that municipalities should relieve physicians of the burden of the indigent; (b) that hospitals should be self-supporting; (c) that there should be a better system of collections from patients; and (d) that municipalities should pay minimum ward rates for all cases.

On Adequate Hospital Provision in the County, the recommendation was approved that "we believe there is adequate provision for hospitalization with certain exceptions, including chronic cases, mental diseases, and tuberculosis especially in children".

On Membership on the Hospital Council of Essex County, the recommendation that our President, Vice-President and one member be appointed as members with full rights and privileges. The President, a member of their Executive Committee, was not approved.

For the Public Relations Committee, Section on Public Health, Dr. Edgar III reported that all public authorities have been advised that the Essex County Medical Society now has a permanent committee to advise with Public Health bodies in the County, and that the Society has adopted an in-

tensive campaign for vaccination and diphtheria immunization of all children in the County. The aim is to maintain the physician-patient relationship with free choice of physician, and in the end, have private physicians assume such medical practice now being done by government employees. For success, every doctor should join in the movement and do his share of this work, whatever his private interests may be.

The reply cards issued to all licensed physicians in the County should be signed by doctors to do the work for the indigent patient; and upon authorization by the Administrative Bureau, the doctor will be paid at the stipulated rate by the government. The responsibility upon our profession will be great to maintain the low incidence of diphtheria already achieved.

Dr. Eagleton, being General Chairman of these Section Committees on Hospitals, Economics, and Public Health, was, on motion by Dr. Pinneo, and seconded by very many, voted the thanks of the County Society, and appreciation of his efforts for the welfare of the profession in New Jersey, with sympathy in his present illness and best wishes for complete recovery.

For the Maternal Commission, Dr. Mount made a report on study of the recent survey under the New York Academy of Medicine which showed that our community is not subject to the unfavorable impression conveyed about other localities, and that a carefully prepared newspaper article for the press had been published.

New members elected were as follows:

Regular: Maelyn Baker, 681 Stuyvesant Avenue, Irvington; Zachary D. B. Balson, 884 South Fourteenth Street, Newark; Emanuel Denholtz, 16 Harrison Place, Irvington; Bernard Fein, 585 Elizabeth Avenue, Newark; Samuel A. Goldberg, 46 Farley Avenue, Newark; Philip Grossblatt, 70 Baldwin Avenue, Newark; David H. Hersh, 685 Springfield Avenue, Newark; Ruth Hilliard, 220 Sussex Avenue, Newark; Edward Philip Levine, 711 Chancellor Avenue, Irvington; Ernest W. Mierau, 1096 Sanford Avenue, Irvington; Samuel R. Roth, 31 Lincoln Park, Newark; J. J. Williams, 88 Walnut Street, Newark.

Associate: C. H. Claus, 239 Twenty-first Street, Irvington; Sidney Peck Cohen, 188 High Street, Nutley; Harold Hantman, 49 Farley Avenue, Newark; Clarence Campbell Stiles, 114 North Nineteenth Street, East Orange; Charles F. Trautwein, 19 Treacy Avenue, Newark.

Associated Physicians of Montclair and Vicinity

Edwin A. Seifert, Secretary

A meeting of the *Associated Physicians of Montclair and Vicinity* was held at the Essex County Isolation Hospital, Belleville, on Friday, January 26, 1934, at 8.45 p. m., with Dr. Charles T. McGinnis presiding. Dr. Frederick E. Sondern, of New York City, gave an address on the subject "Clinical Interpretations of Newer Laboratory Findings". His topic centered on the pathological cytology of the hematopoietic system, differentiating the blood findings in agranular cytosis, acute infectious mononucleosis, and the leukemias. He also made

comparisons between these and primary anemias and described the advantages of the sedimentation test in acute infection.

Dr. Sondern's subject was discussed by Dr. John W. Gray of Newark, and Dr. Maxwell J. Fein of Brooklyn, N. Y.

Dr. James Taylor Hanan, and Dr. Otto Leber of Montclair, briefly commended the successful work which has been accomplished by Dr. Sondern in the field of clinical endeavor.

Refreshments were served after the meeting.

The next regular meeting of the Associated Physicians of Montclair and Vicinity will be addressed by Dr. Howard Lillenthal, New York City, Consulting Surgeon to Bellevue and Mt. Sinai Hospitals. His subject will be "Principles of Drainage in Thoracic Surgery".

Academy of Medicine of Northern New Jersey Section on Obstetrics and Gynecology

Adrian Ralph Kristeller, D.D.S., Secretary

The Stated Meeting of the *Academy of Medicine of Northern New Jersey*, held on January 18, 1934, was under the auspices of the Section on Obstetrics and Gynecology, of which Henry B. Kessler, M.D., is chairman and William K. Pudney, M.D., is secretary. Dr. Edward A. Schulmann, associate professor of obstetrics at the University of Pennsylvania Medical School, gave a very interesting discourse on "Leaves from an Obstetrical Note Book". The paper was discussed by Drs. Bingham, Cosgrove, and Potter.

It was announced that Charles H. Frazier, M.D., John Rhea Barton, Professor of Surgery, University of Pennsylvania, would be the guest at the February meeting under the auspices of the section of Eye, Ear, Nose and Throat, of which Browne Morgan, M.D., is chairman and A. Russell Sherman, M.D., is secretary.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The regular meeting of the *Gloucester County Medical Society* was held at the Hotel Pitman, Pitman, N. J., on the evening of February 15.

Members present were: Drs. H. L. Sinexon, Oran A. Wood and C. C. Sheets, Paulsboro; Edward R. Ristine and R. K. Hollinshed, Westville; J. Harris Underwood, William Brewer, Paul M. Pegau, Duncan Campbell, E. E. Downs, H. B. Diverty, Ralph Moore and William Crain, Woodbury; T. M. Gairdner and C. I. Ulmer, Gibbstown; W. J. Burkett, I. W. Knight, M. F. Lumms and H. B. Chalfant, Pitman; Don Weems, Wenonah; William and Charles Pedrick, Glassboro; E. A. Livengood and Irving J. Stewart, Swedesboro, and Louis Ruttenberg, Mantua.

Visiting delegates were Dr. Oram R. Kline, Camden, and Dr. Allen G. Ireland, representing the State Medical Society.

Dr. I. W. Knight, Chairman of the Public Health

Committee, presented an extensive report, outlining the results obtained at the joint meeting Wednesday with the township committeemen and boards of health members. Action on the report will probably be taken at the next meeting.

Dr. Henry L. Sinexon, of Paulsboro, presented the emergency relief report and a Committee on Welfare was named to cooperate in the work of the State Welfare Committee. The members are: Dr. C. I. Ulmer, Gibbstown; Dr. Horace M. Fooder, Williamstown, and Dr. H. B. Diverty, Woodbury.

Members of the ladies' auxiliary joined the society for a buffet supper.

HUDSON COUNTY

John N. Connell, M.D., Reporter

FEBRUARY MEETING

The regular meeting of the *Hudson County Medical Society* was held at the Carteret Club on Tuesday, February 6, 1934. The meeting was called to order at 9.20 p. m. by the President, Dr. Daniel B. Street.

The Secretary gave a synopsis of the preceding Executive Committee Meeting as follows:

"The subject of reconsideration of the Emergency Relief Administration project was discussed. This was brought up because of a request on the part of many members of the Society who felt that this Society should participate in the E. R. A.

"At a meeting in May, 1933, the Hudson County Medical Society voted down the E. R. A. proposal. However, in response to requests of many members of the Society, it was decided to re-open this proposition to the general membership at this meeting. Since that time, a new project, the Civil Works Administration, has been launched. Men and women are being employed by the State, and paid by the Federal Government for public works. These people are subject to injuries. These injuries are compensable and may be treated by the doctors of the county if the County Society decides to accept the C. W. A. proposition. The rates of compensation for C. W. A. work are the same as those applicable to the present existing rates in all other compensation cases."

The Executive Committee desired to present this proposition to the meeting for consideration. At the conclusion of the summary of the Executive Committee Meeting, Dr. LeRoy A. Wilkes of the State Society was asked to address the Hudson County Medical Society on the work that the State Society is doing. In his talk, Dr. Wilkes explained the working and organization of the E. R. A., and the organization of the Advisory Committees in each County, whose duty it is to work out the details of the E. R. A. with the County Directors. The problem is that of relief of the indigent in need of medical care. The purpose of the organization is to have the burden, which the community has borne, lightened. There is not enough money available to compensate physicians adequately. Under the agreement of the E. R. A., people who are no longer able to pay for medical services are author-

ized to seek the services of their family physician, for which a stated sum of \$1 in the office, \$2 for home calls, and \$25 for obstetrical cases, has been agreed upon. This remuneration to the doctor, Dr. Wilkes continued, does not represent the true value of the services rendered, but is as much as these funds will permit. The procedure is that there shall be appointed in each community a medical relief advisory committee, which shall be an advisory committee to the local director, to enable him to pass fair judgment upon the work done, the eligibility of the patient, and the fairness of the doctor in his charges under this agreement for the services rendered.

Great difficulties have arisen, and the problems in each community are quite different. Two large counties, such as Mercer and Essex, have signed an agreement and are trying to get the plan under way. Those physicians engaged in work for the city, county, or State are not eligible to receive compensation for E. R. A. cases attended.

Dr. Wilkes stated that as soon as the E. R. A. problem was partially solved, the C. W. A. issue was involved. Consequently, the E. R. A. proposition had to be entirely revised. He concluded that Dr. Snedecor, Chairman of the Advisory Committee of the State Society, was able to give the Society more details.

Dr. Snedecor, in giving his report, stated that the matter of the E. R. A. was brought up last Spring by him, and for reasons which the Society felt were very good at that time, the Hudson County Society did not enter into this plan. If the Society decided to go into this plan now, it will have to set up a very strong Medical Relief Advisory Committee. Dr. Snedecor stated that although the C. W. A. proposition complicates the matter somewhat, the same working agreement is being put into effect with the C. W. A. as with the E. R. A. For example, there will be free choice of physicians on compensation cases, payment of fair customary rates of fees, and complete supervision of this work by County Committees. Bills have to be certified to by the County Committees each month for the E. R. A. and C. W. A. projects. If the Society is going to take these projects up for consideration, it will have two big problems, the E. R. A. and the C. W. A. The final thought brought out by Dr. Snedecor was that the State Society wished to co-operate with the Hudson County Medical Society in every possible way.

Dr. Louis Pyle was then asked to address the Society. Dr. Pyle stated that there are two or three things about these plans that the men in Hudson County may not clearly understand. One is that a committee of the County Society is to be appointed, whose duty it is to make a roster of men who are willing to work under the E. R. A. Men who are receiving funds from the city, county or State are not eligible to receive payment for work under the E. R. A. This roster is to be made up by sending out questionnaires to every practitioner in the Society.

The roster is then approved by this committee. They have the authority to remove any man from the list, or suspend him for submitting bills to which he is not entitled.

Dr. Pyle emphasized the fact that the C. W. A. project had nothing to do with the E. R. A. plan. He stated that at the present time Hudson County has not a list of physicians working under this plan. If Hudson County doctors are to treat these cases under the Federal Compensation laws, then there must be in Hudson County at least a committee formed and a roster made up.

Dr. Marshak moved that the Society reconsider its action of last May in regard to the E. R. A. project. This motion was seconded.

Dr. Waters then spoke on the reconsideration of the E. R. A. project. Dr. Waters said that Hudson County is one of the few counties that has not gone on record as favoring the E. R. A. Dr. Waters stated that if we accept the E. R. A. proposition, we must recognize an immediate and total change in our relationships to the public. The medical men, Dr. Waters said, have been taking care of indigents for a good many years, and as far as he can see, the profession has not suffered very much from doing it.

He continued by saying that this is the first step toward fee fixing for the entire profession. He felt that the project will be continued only so long as the emergency continues. He also brought out the fact that free choice of physicians under the E. R. A. plan is not going to help the younger men, as people will go to the old family physician and to the more experienced doctors.

Dr. Waters concluded by stating that he thought it unfair to exclude city, county, and State doctors from compensation. Dr. Waters was opposed to the Hudson County Medical Society accepting the E. R. A. proposition.

Dr. B. T. D. Schwarz stated that he had sent out questionnaires to the various counties who supposedly were getting the plan under way, only to receive extremely discouraging replies from all of them. The general impression Dr. Schwarz received was that the E. R. A. was an almost defunct organization, and that in going over the relief list, 90 per cent of the men on the E. R. A. are now working, and are not eligible at all for the E. R. A. relief.

Dr. Barbito then spoke on the question of the E. R. A., and said that he felt that the project was only in keeping with the times. He stated that whether we like it or not, there was going to be some sort of socialization of medicine; and that since this project was a trend of the times, we must accept it.

On a vote as to whether or not the Society should reconsider the E. R. A. proposition, it was decided that the Hudson County Medical Society reject the E. R. A. project.

Dr. Maurice Shapiro moved that a committee be appointed to take care of C. W. A. cases. The motion was seconded, and carried.

Dr. Louis Pyle suggested that this has to be done in the same manner, although not connected with the E. R. A. He moved that an official committee of five men be appointed to get a roster of the Society for the C. W. A. work. This was seconded and carried.

Dr. Maras requested that the doctors who do the C. W. A. work report the total amount of the work

and the compensation they receive to that committee, and that the committee in turn will publish those facts monthly in the Bulletin of the Society. This was seconded and carried.

The President then turned over the meeting to Dr. James F. Norton for the Scientific Session, which was presented by the Staff of St. Francis Hospital, Jersey City. The program consisted of a "Symposium on Diseases of the Biliary Tract."

MIDDLESEX COUNTY

G. F. Hilker, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held at the Metuchen Inn, Metuchen, New Jersey, January 17, 1934. Dr. Joseph Mark presided.

The following applications for membership were received and sent to the Medical Ethics Committee: Dr. Goldberg, Perth Amboy; Dr. Jacobson, Perth Amboy; Dr. Lesh, South Amboy; Dr. Glasser, New Brunswick; Dr. Szuch, South River; Dr. Rothfuss, Woodbridge.

Dr. Fithian gave a report on the activities of the Arbitration Committee, including the status of school and city physicians. A report was also given governing procedure to be followed by doctors in regard to CWA cases.

Dr. Mann, Chairman of the Public Health Committee, read a letter from the Executive Secretary of the State Medical Society of New Jersey regarding a plan for securing the cooperation of physicians on public health work, including periodic health examinations of children and diphtheria and small-pox inoculations. Doctors willing to do this work as outlined by the rules and regulations of the committee will notify Dr. Mann.

Dr. Mark expressed the sorrow of the society for the death of Dr. Frank C. Johnson and appointed a committee to draw up the proper resolution to be sent to Dr. Johnson's family.

Dr. Mann and Dr. Berkow, of Perth Amboy, and Dr. McKiernan, of New Brunswick, were elected Delegates-at-Large for a three-year term. Dr. Joseph Mark, of Woodbridge, was elected a member of the State Society Nominating Committee for 1934. Dr. Marshall Smith, of New Brunswick, was elected Treasurer and Dr. G. F. Hilker, of Perth Amboy, Reporter.

Dr. London spoke of the work of the Tuberculosis Division in the county which is undertaking a survey of childhood tuberculosis. The project is financed by CWA funds and has two main objectives: (1) Contacting known cases on file for the past ten years and trying to trace the source of infection; and (2) tracing contacts with positive cases, and having the children tuberculin tested and x-rayed.

Dr. Mark advanced the idea that the social status of the society would be bettered by having an annual dinner dance. This was referred to the Executive Committee for action at the next meeting.

Dr. Scammell, District Councilor of the Society, was a guest and gave his opinion on the relations of City Physicians to the CWA.

The speaker of the evening was Dr. Francis J. McCauley, of Newark, who spoke on the treatment of common skin diseases and skin cancer. The talk was profusely illustrated with lantern slides and proved extremely valuable both to general practitioners and dermatologists.

After the meeting a light dinner was served.

Medical Section of Rutgers Club New Brunswick, N. J.

John H. Rowland, M.D., Secretary

The regular monthly meeting of the *Medical Section of the Rutgers Club* was held at the Woodrow Wilson Hotel on Friday evening, January 26, 1934, with 25 members present. The meeting was called to order at 9.15 p. m. by Dr. B. M. Howley, Chairman.

SCIENTIFIC MOVIES

Mr. McClinstock, of Rutgers University, presented some very interesting moving pictures showing various phases of the life cycle of insects, together with many of their characteristics; also some most interesting pictures depicting the habits of bird life; and other pictures showing movements in the growth of plant life not visible to the naked eye; i.e., the picture in one or two minutes would show the growth of the plant for two weeks or more.

A short business session was held and refreshments were served.

MONMOUTH COUNTY

Samuel Edelson, M.D., Reporter

The monthly meeting of the *Monmouth County Medical Society* was held at the Fitkin Memorial Hospital, Asbury Park, on January 24.

Applications for membership were received from Dr. S. E. Becker, of Keyport, and Dr. George Stevenson, of Middletown.

Dr. J. E. Maher, of Long Branch, President of the Society, outlined his policies for the year. After referring to the inactivity of the society fifteen years ago, he ascribed the causes of its growth to better means of travel, medical publications, new blood, more hospitals, and greater specialization in the practice of medicine. He believed that society would demand that competent medical service shall be available, preferably by family doctors, but by the State if they fail to provide an efficient system of delivering the service to all.

Dr. Maher concluded with the following unique suggestions which are worthy of consideration by other county societies:

"Are we satisfied with our organization as it is now functioning? Is the Society serving its members to the best of its ability? What changes do you desire? Because of some criticism that I have heard, I beg the frankest discussion of our policy.

"The two most criticized committees are the Executive and Nominating Committees. Every member knows why those committees are in existence. They are your creation.

"The failure of the Society to do full justice to each member is your problem for discussion. I want you to give some thought to it and after two

months of individual study have a round table discussion. I want each member to feel that he is getting benefit from this Society, and is an integral part of it.

"For the next few months, I extend to each of you an invitation to be present at the executive meetings, in order to acquaint you with its duties. It will also give you the opportunity of deciding whether this committee functions to the best interests of the society in assuming its business policy; or whether you would prefer the Society, as a whole, to handle the business, and, therefore, scrapping the scientific interest; or to hold two meetings a month, one a business session and the other a scientific meeting."

In the Scientific Session, Dr. Joseph Wiener, Cardiologist to the Monmouth Memorial Hospital, gave an address on Angina Pectoris.

Asbury Park Medical Society

Samuel Edelson, M.D., Reporter

The Asbury Park Medical Society, an organization composed largely of local medical men who are County Society members, had a meeting on January 9, 1934. At this meeting Dr. W. E. Caldwell, of Sloane Maternity Hospital, New York City, presented new interpretations in the study of the female pelvis, based upon a study of several hundred pelves in the Smithsonian Institute and in the Museum of Natural History. The various types of pelves were then carefully studied during pregnancy with the aid of the x-ray. Deductions were made as to the ultimate effects produced during labor. Dr. Caldwell made notable revisions in our previous conceptions of the female pelvis, showing by careful measurements the rarity of the so-called simple flat pelvis or platy-pelloid pelvis, and the common incidence of the male or android pelvis with its serious complications. The other two types of pelves, according to his classification, are: the normal or gynecoid form, and the anthropoid form, commonly found in negroes. Dr. Caldwell gave the percentages of the various types of pelves studied.

FITKIN MEMORIAL HOSPITAL

A Staff conference of the Fitkin Memorial Hospital was held on January 14, 1934. The deaths which had occurred were discussed. Of especial interest was the report on J. M., aged 77 years, who died within twenty-four hours of admission. Autopsy showed what appeared to be an endothelioma of the pleura. Microscopic study, however, showed a renal carcinoma with metastases to the lymph nodes and pleura. Of considerable interest, also, was the record of J. H., aged 54 years. Autopsy grossly revealed what appeared to be a suppurative mediastinitis with miliary abscesses of the left lung. Study showed an adeno-carcinoma of the bronchus with metastases to the tracheo-bronchial glands. The mediastinitis was secondary to a perforation of the main bronchus.

The Obstetrical Service presented a case of placenta praevia with air embolus.

The Surgical Service presented a case of perforated gastric ulcer. Fifteen days after hospitaliza-

tion the patient showed a rising temperature. At the second operation, an abscess was found in the falsiform ligament of the liver.

The Medical Service presented two patients:

(1) A case of urticaria with 34 per cent eosinophiles.

(2) A severe case of pernicious anemia with an excellent response to parenteral liver.

The Neurological Service presented a patient with severe pain due to sarcoma, with relief by chordotomy.

MONMOUTH MEMORIAL HOSPITAL

The regular Monthly Conference of the Monmouth Memorial Hospital of Long Branch, New Jersey, was held on January 8, 1934.

The following services reported:

(1) Surgical Service:

(a) Case of general peritonitis following perforation of cecum, cecal polyp probably being the primary cause of the perforation.

(b) Case of Hirschsprung's disease.

(2) Eye, Ear, Nose, and Throat Service:

(a) Pan sinusitis.

(b) Mastoiditis in a child five months of age.

(c) Sarcoma of the right antrum.

(d) Enucleation, intraocular abscess.

(e) Carcinoma of esophagus.

(f) Asthma, with right antrum infectino.

(g) Mastoiditis with labyrinthian symptoms; operation, improvement.

(3) Medical Service:

(a) Syphilis associated with intra-bronchial tumor.

(b) Impending acidosis in a diabetic.

(c) Hypoglycemic shock.

(d) Erythema nodosum, positive streptococcus viridans blood culture.

(4) Pediatric Service:

(a) Tonsillitis followed by nephritis with anuria. Blood urea 188 mg.

(5) Neurological Service:

Female, 10 years of age, while in school she suddenly lost her speech and fainted. Right sided paralysis ensued. Six days later was admitted in a mild stupor with right hemiplegia and hemihypaesthesia, bilateral papilloerema and sixth nerve weakness. Eleven days later the headache and drowsiness increased, vomited frequently. The diagnosis of left fronto-parietal tumor with hemorrhage was confirmed by operation when a subcortical tumor was removed. Two and one-half months later she walks with slight spasticity of the right leg. Motion in the right arm has improved. There is some facial weakness. No papilloedema is present and there is a full recovery of speech.

At a meeting on January 9, 1934, the Obstetrical Staff of the Monmouth Memorial Hospital of Long Branch, New Jersey, had as a guest Dr. W. E. Caldwell, Associate Director of the Sloane Maternity Hospital of New York City and Consulting Obstetrician of the Monmouth Memorial Hospital of Long Branch, New Jersey. A report of the work of the months as well as statistics for the year 1933 was

read by Dr. Robert A. MacKenzie, Director of the Obstetrical Department. This report revealed a notably low incidence of Cæsarian sections. There were three cases of low or cervical type cesarians in a total of 329 ward patients delivered. The statistics revealed a maternal mortality of less than one per cent. There were three maternal deaths during the year. These were reported and discussed carefully. Only one was felt to have been preventable. The mortality rate of less than ten per thousand was not considered too high in view of the large number of complicated and pathologic cases admitted to the hospital.

Dr. William Shanik read a short paper on the management of occipito-posterior presentations.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A special meeting of the *Morris County Medical Society* was held the evening of February 15, 1934, at The New Jersey State Hospital at Greystone Park, with President Frost presiding and 40 members present.

The purpose of the meeting was to discuss and act upon the final plan for the Morris County E. R. A. and C. W. A. programs for presentation to the State Society.

Chairman Sherman of the society committee, at the request of the President, explained in detail the delays and preliminaries leading up to the final plan. There was general discussion from various angles and attitudes, after which approval of the final plan as submitted was voted, with no dissenting voice.

Legislative matters were discussed with particular reference to bill S73, which was described as the old Osteopath bill 226 of last year. On this bill action was unanimously taken that the society go on record as opposed to the bill; that the Secretary communicate with the Morris County members of the legislature asking them to vote against the bill and use their influence to defeat it; and that the members of the Legislative Committee in charge of the bill be also notified of the opposition of this society.

After adjournment refreshments were served.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society*, combined with that of the Passaic Practitioners Club, was held in the Ritz Ball Room, Passaic, February 8 at 9 p. m., with Dr. H. F. Willard, President of the County Society, presiding.

The scientific program began with a paper on "Modern Aspects of Deafness", by Dr. E. A. Atwood, of Paterson.

ABSTRACT

Deafness in childhood is due in most cases to infection. Pneumococcus infection resulted in an otitis media in one out of three cases. Scarlet fever and measles were the next most important infections resulting in otitis media. Removal of foci of infection was most important to prevent deafness.

Deafness in young adults is due principally to otosclerosis and chronic catarrhal conditions. Treatment of otosclerosis at this time is unsatisfactory, and proper hearing aids are indicated.

Deafness in later life is due largely to nerve-degeneration, and here treatment consists mainly of proper hearing aids.

Dr. Ralph Vreeland, of Paterson, presented a paper on "Management of Acute Otitis Media and Complications".

ABSTRACT

The indications for myringotomy were stated. First, when suppuration is present. Second, when the light reflex is gone and the drum is bulging. Third, in cases where a latent infection is suspected, especially in infants with diarrhea, vomiting and fever. Irrigations could be used if desired, but are not essential.

Conservative measures should be used, but not too long before resorting to incision. Too early incision was discouraged.

Silent ears due to pneumococcus infection were always treacherous, and resulted in mastoiditis in 80 per cent of the cases.

No attempt should be made to make the classical incision, as that was rarely possible to do.

After myringotomy, conservative treatment consisting of rest in bed, nourishing food, tonics, and hygienic measures should be followed.

If the otitis does not clear up promptly, complications should be suspected. Increase of temperature, a continued temperature, increase of discharge, or cessation of discharge, increase in pain and tenderness over the mastoid, sagging of the posterior canal, positive X-ray evidence, are all indications of mastoid complication.

When the diagnosis of mastoiditis has been made, delay in operating increases the chances of sinus complication and meningitis, brain abscess, and thrombosis.

External otitis media is treated either by incision under general anesthesia, or packing and external compresses.

* * *

The two papers were discussed by Dr. C. W. Harreys, Dr. Leonard Matthews, Dr. E. B. Connolly, Dr. W. MacMillan, Dr. E. C. Reynolds, Dr. Vernon Hughes, Dr. E. Reeves.

A report from the Public Health Committee was read by Dr. Wright MacMillan, chairman. The President of the Women's Auxiliary, Mrs. Hagan, had asked that speakers be provided to appear at various women's clubs to present various phases of Public Health work.

A resolution was adopted by the committee that the Passaic County Medical Society endorse the program of the State Medical Society to bring about diphtheria immunization of young children by the family practitioner throughout the state. This resolution was presented to the society and was unanimously accepted.

The following Delegates to the Annual Meeting of the State Society were elected: Drs. John McCoy, W. MacMillan, J. H. Carlisle, F. W. Ash, Charles J. Murn, J. Roemer, T. J. Gillon, Louis Shapiro, Norman Dingman, R. J. Vreeland, W. W. Hall, William Sutherland and A. L. Mackel.

UNION COUNTY

Russell A. Shirrefs, M.D., Reporter

The regular quarterly meeting of the Society was held at the Elizabeth General Hospital on the evening of February 14, Dr. Watson B. Morris presiding. The guest speaker was Dr. Clarence E. de La Chapelle, Assistant Professor of Medicine, New York University, who spoke on the subject "Some Clinical and Pathological Aspects of Heart Disease". His interesting talk was illustrated by many lantern slides and at the conclusion a rising vote of thanks was tendered him.

In addition to committee reports and much other routine business, the following physicians were elected to membership: Dr. T. R. Austin, 16 Aldene Street, Cranford; Dr. Samuel H. Sherman, 81 Elmora Avenue, Elizabeth; Dr. Leonard D. Williams, 518 Park Avenue, Plainfield; Dr. J. M. Lyerly, 116 Putman Avenue, Plainfield; Dr. Walter S. Booth, 318 Grier Avenue, Elizabeth; Dr. George Diamond, 812 Park Avenue, Plainfield; Dr. Dominic V. Vitale, 681 Newark Avenue, Elizabeth.

A collation followed the meeting and a social hour was enjoyed.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The *Warren County Medical Society* held a regular meeting at the Warren Hospital, Phillipsburg, N. J., Tuesday evening, January 23, 1934, with the President, Dr. Emory Krausz, presiding, and eleven members and five visitors present. Dr. Charles Lyon, of Phillipsburg, was appointed secretary pro tem.

Dr. F. Shimer and Dr. C. Lyon were appointed a committee to draw up resolutions of respect and condolence on the deaths of Dr. Frank McKinstry, of Washington, and Dr. Charles B. Smith, of Washington.

Dr. L. Bloom, as our member of the Welfare Committee of the State Society, made a report to the society concerning the Medical Relief Agreement, and the diphtheria immunization campaign to be conducted soon by the members of our County Society.

Dr. L. Bloom was appointed as our member on a special committee to act with a similar committee from the State Society and from the American Medical Association on the subject of medical practices.

It was voted that we instruct our President to send to each one of our members a questionnaire regarding contract practice.

It was voted that we recommend to the Trustees of the State Society the appointment of Dr. L. Bloom as Trustee to fill the unexpired term of the late Dr. Charles B. Smith.

Dr. H. B. Bossard was elected Reporter for the unexpired term of the late Dr. Charles B. Smith.

Dr. Krausz then introduced Dr. F. Zillessen, Pathologist of Eastern Hospital, who read a very interesting and instructive paper on Allegory.

After general discussion, a rising vote of thanks was given Dr. Zillessen and the meeting adjourned.

Communications

We have received a letter from Mr. H. C. Deuchler, a Guildcraft Optician of East Orange, N. J., in which he commends the Journal as follows:

"The editorial by Dr. Linn Emerson on page 66 of your February Journal, is eminently truthful. We of the Guild of Prescription Opticians of America are advertising and advising that the eye physician is the only person who is qualified to make a diagnosis of refraction errors and prescribe for their correction.

"I am pleased to say that I have always found the eye physicians ready and willing to cooperate with us whenever we find patients who feel that they cannot afford to pay the examination fees. The eye physician meets this emergency by reducing his fee. We in turn, are always ready and willing to cooperate with the eye physicians by making a reduction in proportion to his.

"The physicians of New Jersey may be assured of our cooperation."

Obituaries

DR. ROBERT C. POTTER

POTTER, Robert C., M.D., Newark eye and ear specialist and former chief of the Eye and Ear Section of St. Michael's Hospital, died on February 6 after an illness of eight weeks from intestinal grippe at his home, 91 Watson Avenue, East Orange. He was 63.

Dr. Potter was born in Jersey City and was graduated from New York University Medical School in 1893. He started practicing general medicine under Dr. John Daly, of Rahway. He began specialization in diseases of the eye and ear twenty-three years ago. He was on St. Michael's Hospital Staff thirty-eight years, succeeding the late Dr. T. Y. Sutphen as head of the department. He retired from the hospital three years ago because of poor health, although he maintained his office at 25 Fulton Street, Newark.

Dr. Potter lived several years in Newark before going to East Orange ten years ago. He was a member of the Essex County Medical Society and the Academy of Medicine and an honorary member of the Practitioners' Club of Newark.

DR. J. WELLINGTON CRANE

CRANE, J. Wellington, M.D., aged 57, Medical Director of the State Prison at Trenton, died Sunday, February 18, 1934, at Mayo Brothers Clinic, Rochester, Minn.

He was born in Irvington and was educated at Vanderbilt University. He practiced medicine in Newark ten years before his appointment by Governor Fort June 1, 1903, as Resident Physician of State Prison.

Dr. Crane belonged to many medical societies, including the American Medical Association and the American Academy of Ophthalmology and Otolaryngology.

He is survived by his wife, Mrs. Caroline Hauer Crane, and six children.

Woman's Auxiliary

MESSAGE FROM THE PRESIDENT

February 15, 1934.

To Members of the Woman's Auxiliary to
The Medical Society of New Jersey:

Greetings:

The term of your present officers is fast drawing to a close. We should hasten to finish work already started and get reports ready to present next June at Atlantic City and Cleveland. The Auxiliary is planning for a very short business session and plenty of entertainment for us at Atlantic City. Please urge your husband to attend with you, as many important matters should be considered by both of you. Patrick Henry was right as "United we stand, divided we fall."

The Speakers' Bureau, to spread authentic health information to the public, should be well established in each county this year, even if there is but two or three speakers registered.

Please present copies of Hygeia to those who are attending meetings of other clubs and organizations whenever you can. Plenty of sample copies or back numbers may be obtained free from Chicago.

Which county will get the prize for increase in membership this year?

The next Board Meeting will be held in the Hotel Douglas in Newark on March 12.

With best wishes for a successful year to all,

Mrs. Harry Varsil Hubbard,
President of Woman's Auxiliary
of New Jersey.

Atlantic County

Mrs. Manuel J. Mally, Reporter

The Woman's Auxiliary to the Atlantic County Medical Society met on February 9 at 8 o'clock in the Tower Room of Haddon Hall. Mrs. Joseph Poland presided.

In the absence of Mrs. Daniel Reyner, Chairman of the Card Party held in the Madison Hotel on February 7, Mrs. Poland reported \$42.57 as the proceeds.

A question arose as to whether it was necessary for this Auxiliary to have a Public Relations Committee. Discussion brought out the fact that all of our public schools have excellent Child Study Groups, where health problems, welfare problems and mental hygiene problems are taught and discussed. Since these organizations seem to take care of all work along these lines, it was decided not to have such a committee.

Mrs. Edwin H. Harvey was appointed Chairman of the Nominating Committee, with Mrs. W. Blair Stewart and Mrs. John Irwin assisting.

Mrs. W. Blair Stewart proposed Mrs. Richard Bew, Sr., and Mrs. Richard C. Bew as new members.

Mrs. E. H. Harvey announced that flowers had been sent to members who were ill.

Names of needy patients were submitted to the Chairman of the Distress Committee.

After the business had been completed, Mrs. Harvey and Mrs. Stewart gave an illustrated talk entitled "A Peep into Other Lands," including Ireland, England, France and Switzerland. They brought samples of the arts and crafts of the foreign countries for our examination.

Bergen County

Mrs. LeRoy W. Black, Reporter

The January meeting of the Woman's Auxiliary to the Bergen County Medical Society was held at the Hackensack Hospital, with the largest number present we have had in some time. After a brief business meeting, Mrs. Samuel Alexander, the President, turned the meeting over to Mrs. A. W. Bickner, program chairman, who introduced the speaker, Mrs. E. Bryant. Mrs. Bryant, who conducts a play school in Rutherford, N. J., spoke on "Child Training". She has studied playground and nursery school work at the Pennsylvania School of Social and Health Work and Temple and Cornell Universities. Her suggestions and experiences were tremendously interesting and everyone had questions to ask.

The meeting of the Bergen County Medical Society was held at the same time. Following the meetings, the new President, Dr. Arcangelo Liva, entertained the members of the society and their wives at his home in Rutherford.

Burlington County

Reported by Mrs. M. M. Schisler

The Woman's Auxiliary to the Burlington County Medical Society met December 13, 1933, at the home of Mrs. J. H. Hornberger. Mrs. J. H. McDonald presided. There were twenty-two members and ten guests present.

The annual contribution was sent to the Burlington County Hospital.

The programs as submitted by the committee was approved as follows:

Luncheon and musicale at Mirrow Bank, Browns Mills, N. J., at 1 p. m., Wednesday, March 7, 1934. The State President will be in attendance.

Reciprocity tea at the Community House, Moorestown, N. J., at 2 p. m., Wednesday, May 2, 1934. Speaker and musicale.

After the business meeting a social hour followed. Tea was served by Mrs. Hornberger, and several members enjoyed a game of bridge.

Camden County

Mildred B. West, Publicity Chairman

The January meeting of the Woman's Auxiliary to the Camden County Medical Society was held at the home of the Vice-President, Mrs. Joseph E. Roberts, Haddonfield, on January 9 at 2.30 p. m., with Mrs. Lippincott, the President, presiding.

The reports of committees were given and Mrs. Fithian reported that Hygeia had been placed in the public schools throughout the county which were not already subscribing for it.

Mrs. Casselman gave a report of the mid-annual luncheon of the State Auxiliary which was held in Trenton on January 8.

Upon a suggestion from Mrs. Lippincott, it was voted to buy a new desk for the meeting room of the County Medical Society.

The guest speaker was Miss Lula P. Dilworth of the State Department of Public Education, who gave a very interesting talk on "New Jersey's School Health Program".

Our Secretary, Mrs. O. W. Carlander, gave a review of "Coming of Age in Samoa" by Margaret Meade, which was thoroughly enjoyed by everyone.

After the meeting, tea was served by the Hospitality Committee with Mrs. Joel Fithian and Mrs. Levi Hirst pouring.

Members of the Burlington and Gloucester County Auxiliaries and all the different women's organizations of Camden County were guests of the Woman's Auxiliary to the Camden County Medical Society at their Public Relations meeting held in the Junior Ballroom of the Walt Whitman Hotel on February 6. Mrs. A. Haines Lippincott, the President of the Auxiliary, introduced Mrs. Arthur J. Casselman who had charge of the meeting.

Dr. Arthur J. Casselman, who is a member of the State Board of Health, told us that they would be very glad to supply medical speakers for groups of twenty-five or more if we would write to the State Board of Health and ask for a speaker.

Mrs. Harry Hubbard, our State President, was one of our guests and gave a short talk.

Mrs. Casselman then introduced Mrs. Alfred R. Grey, the Chairman of the Woman's Auxiliary to the Lankenau Hospital Research Institute, who in turn introduced Dr. Stanley P. Reimann, director of the Research Institute. Dr. Reimann spoke on "How Several Kinds of Growth Behave Under Experiment". It was a very interesting talk and thoroughly enjoyed by everyone.

A social hour followed the meeting, with tea being served by the Hospitality Committee. Mrs. E. A. Y. Schellenger and Mrs. E. C. Pechin poured.

Essex County

Reported by Mrs. H. Alton Schachter

The Woman's Auxiliary to the Essex County Medical Society held its regular meeting at the Academy of Medicine, Newark, January 22. Dr. Edward Sprague, President of the Essex County Medical Society, addressed a large group of enthusiastic members, as did the State President of the Auxiliary, Mrs. Henry V. Hubbard. Dr. H. A. Brodtkin spoke, describing the urgent need for all who are interested in public health to support the timely Tugwell bill now pending in Congress.

The Tugwell bill is well designed to prevent the manufacture, shipment and sale of misbranded, or

adulterated food, drink, drugs or cosmetics, and to regulate the traffic therein. It is the finest bill of its kind proposed since the passage of the National Food and Drugs Act, in 1906, and its primary purpose is to strengthen, implement and supplement the present Food and Drug Act. Dr. Brodtkin in his talk indicated in convincing and unmistakable manner the urgent need for this bill, and pointed out clearly that unless unselfish and public-spirited citizens throughout the country rally to the support of the proponents of the Tugwell Act, the organized interests who are now fraudulently exploiting the unsuspecting public and mulcting them out of millions of dollars annually, and at the same time contributing to their ill health, will defeat this bill. "Weak as the present law is, it has done a great amount of good," the doctor declared, and then proceeded to state how "the most false and fraudulent claims are now made with impunity, over the radio, via bill-boards and magazines, etc., about drugs that not only will not do the things claimed for them, but are dangerous and unsafe for anyone, even though he be enjoying robust health, to employ as directed by these unscrupulous manufacturers and vendors."

Gloucester County

Reported by Mrs. Henry B. Diverty

A business meeting of the Woman's Auxiliary to the Gloucester County Medical Society was held at the Pitman Hotel, Pitman, N. J., February 17 at 9 o'clock. The President, Mrs. E. I. Downs, conducted the meeting.

After adjournment the Social Committee for the evening, Mrs. W. W. Pedrick, Mrs. I. W. Knight and Mrs. F. G. Wandell, were in charge.

The following members were present: Mrs. Downs, Mrs. C. I. Ulmer, Mrs. W. W. Pedrick, Mrs. Paul Pegau, Mrs. I. W. Knight, Mrs. R. K. Hollinshead, Mrs. Fuller Sherman, Mrs. H. W. Wright, Mrs. Chalfont, Mrs. David Brewer and Mrs. H. B. Diverty.

Hudson County

Reported by Caroline Culver

The regular monthly meeting of the Woman's Auxiliary to the Hudson County Medical Society was held on the afternoon of Monday, February 5, at the Y. W. C. A. house, the President, Mrs. Frank P. Nicholson, in the chair.

In the absence of the Treasurer, Mrs. Nicholson read her report of the recent card party, held on the afternoon of January 24 at the Y. W. C. A. The returns were very gratifying, and we have a goodly sum to add to our charity fund.

Mrs. James Murphy reported on the radio health talks being given on Mondays and Thursdays. She said she had enjoyed the talks and advised us to listen whenever possible.

Mrs. Nicholson reported the Executive Board Meeting held in Trenton at the Y. W. the second Monday in January.

The speaker at that meeting stressed the enforcement of the Pure Food and Drugs Act, rather than to substitute a new one which does not appear to meet the full demands of the times. To do this effectively, the Auxiliary members were urged to write letters to Congresswoman Mary Norton and also to Senators Kean and Barbour asking them to press measures that will ensure the full enforcement of the present law which covers details that seem, to those watching, to be overlooked in many ways.

One new member was welcomed, Mrs. O. H. Mustermann, of Union City.

The Chairman of Legislation, Mrs. A. Ruoff, who is a lawyer in her own right, reported on false advertising on the radio, and also concerning the necessary requirements for establishing a private home for aged and convalescing physicians.

Under new business, the Auxiliary voted to give \$25 to the Y. W. C. A. Campaign Fund, and \$25 to the Georgia Warm Springs Foundation, and to pay \$5 a month toward the rent of an elderly couple.

The speaker for the afternoon was Principal Edward Berman of the Junior High Vocational School in Bayonne, who explained what modern educational methods are aiming to do for the underprivileged girl and boy. Dividing the school pupils into four groups, he discussed the educational needs, as far as the state's provision is concerned. These, he said, are, first, the super-normal child, who can look out for himself and is never a problem; next, the normal child, who is a problem only in the matter of economic provision for advancement; then the dull-normal child, who needs watchful care and much assistance in the home circle to get the full advantage of what the school can provide; and last, the sub-normal child, nearly three-fourths of whom end in some institution for special care.

Mr. Berman dwelt on the many phases of vocational work which have been developed to educate those children who seem unable to fit into the regulation mold of standard education.

His talk proved most instructive to the members and he was given a rising vote of thanks for his courtesy in coming and explaining this interesting subject.

The usual discussion and social hour with tea followed, when Mrs. Herman Behrens was Chairman of hostesses.

Passaic County

Reported by Mrs. E. F. Leonard

Professor Ira D. Gerard, of the New Jersey State College for Women, was the speaker at the quarterly meeting of the Woman's Auxiliary to the Passaic County Medical Society held at the Woman's Club. His subject was "The New Food and Drugs Act".

Mrs. William Dwyer, President, presided at the business session which preceded the talk.

Mrs. Orville R. Hagen, Chairman of the Public Health Committee, gave a report on the recent meeting arranged by her committee at the Board

of Health Building with representatives of all the health agencies in the county. "Supervision of Health of the Pre-School Child" is the health project of the society this year and discussion of this work was carried on at the meeting. It was found that there are only four Parent-Teacher Associations in this city and six baby welfare stations, so additional groups must be found through which the society can cooperate. The Society voted to recommend to the county medical society that plans be made for work to be carried on among pre-school children, with immunizations, vaccinations and health examinations given before a child enters school.

Mrs. J. E. Phelps, Chairman of the Membership Committee, reported eight new members. Mrs. E. J. Marsh, Chairman of the Widows' and Orphans' Fund, gave a report on the work.

Mrs. Charles B. Russell, Chairman of the Program Committee, announced that Mrs. Hagen will be in charge of the March Meeting when a public health program will be arranged. The annual luncheon of the society will be held in May.

Following Professor Gerard's address tea was served. Mrs. Bart Botbyl, Chairman, was assisted by Mrs. Joseph Barr, Mrs. Armand DeRosa, Mrs. L. F. DeYoe, Mrs. G. B. Flood, Mrs. R. I. McDonald, Mrs. Charles Mitchell, Mrs. George Walton and Mrs. A. N. Pelusio.

Union County

Mrs. George Seymour, Reporter

The Woman's Auxiliary to the Union County Medical Society held its regular meeting in Elizabeth at the home of Dr. and Mrs. C. Schlichter, Wednesday, February 14. Mrs. Harry Bowles, the President, presided.

Delegates were appointed to attend the Annual Convention in Atlantic City in June, Mrs. H. Bowles, of Summit; Mrs. C. Schlichter, of Elizabeth, and Mrs. G. Orton, of Rahway; alternates, Mrs. G. Laird, of Westfield, Mrs. A. Casselli and Mrs. J. Hanrohan, of Elizabeth.

Mrs. H. Corbusier, of Plainfield, was elected Chairman of a committee to plan a public relations meeting to be held some time in March, the place to be designated.

H. W. Armbruster, of Westfield, spoke on "Lack of Enforcement of the Wiley Pure Food and Drug Act".

A delightful bridge party was held at the home of our President, Mrs. Bowles, in Summit, November 4, 1933, the proceeds of which were added to our scholarship fund.

Auction bridge was enjoyed by more than forty members and their friends at the Clara Louise Tea Room in Plainfield January 30. Mrs. H. Hubbard, State President, gave a short talk on "Hygeia". The money realized from this luncheon was used to place this health magazine in schools and libraries throughout Union County.

After the meeting adjourned, dainty refreshments were served by our hostess.

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RAINFALL (In inches- 40-year average)	8	9.6	8.1	3.2	1.4	2.3	2.4	2.6	1.0	6	7.6	10.9
HUMIDITY Monthly (40-year average)	AM 61 PM 35.3	AM 61 PM 27.7	AM 61 PM 22.4	AM 61 PM 22.6	AM 61 PM 15.9	AM 61 PM 17.7	AM 61 PM 35.7	AM 61 PM 29.0	AM 61 PM 26.5	AM 61 PM 41.1	AM 61 PM 48.1	AM 61 PM 29.9

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The Merck Institute of Therapeutic Research, Rahway, New Jersey, announces the appointment of Dr. Eugene Maier as Chief Bacteriologist.

Dr. Maier is a graduate of the University of Tuebingen, Wurtemberg, Germany, and completed his studies at the University of Erlangen, Germany.

Dr. Maier was associated with the Rockefeller Institute of New York as Research Assistant from 1926 to 1930. Since 1931, up to the time of becoming associated with Merck & Co., Inc., Dr. Maier has been at Bellevue Hospital, New York, in the Department of Pathology, as bacteriologist for the Tuberculosis Division of Columbia University.—Adv.



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ELIAS J. MARSH	Paterson	HARRY R. NORTH (1936)	Trenton
		CHARLES B. SMITH (1936) (Died Dec. 19, 1933)	Washington

COUNCILORS

First District (Union, Warren, Morris and Essex Counties)	CHRISTOPHER C. BELING, Newark (1936)
Second District (Sussex, Bergen, Hudson and Passaic Counties)	S. T. SNEDECOR, Hackensack (1935)
Third District (Mercer, Middlesex, Somerset and Hunterdon Counties)	F. G. SCAMMELL, Trenton (1934)
Fourth District (Camden, Burlington, Ocean and Monmouth Counties)	JAMES A. FISHER, Asbury Park (1936)
Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties)	ALDRICH C. CROWE, Ocean City (1935)

DELEGATES

Delegates to the American Medical Association

WALT P. CONAWAY	Term expires 1934
JOHN F. HAGERTY	" " 1934
E. R. MULFORD	" " 1935
A. HAINES LIPPINCOTT	" " 1935

Alternate Delegates

PHILIP MARVEL	Term expires 1934
GEORGE H. SEXSMITH	" " 1934
S. B. ENGLISH	" " 1935
STEPHEN T. QUINN	" " 1935

SCIENTIFIC SECTIONS

Chairmen for the Annual Meeting of 1934

Section	Chairman
Eye, Ear, Nose, Throat	S. T. HUBBARD, Hackensack
Pediatrics ..	WALTER B. STEWART, 8 N. Tallahassee Ave., At. C'y
Radiology ..	GEO S. REITTER, 144 Harrison St., East Orange
School Physicians ..	A. G. IRELAND, Trenton Trust Bldg., Tr'n

STANDING COMMITTEES

Committee on Scientific Work

LOUIS C. LANGE , <i>Chm.</i> , Weehawken	Term expires 1934
RALPH K. HOLLINSHED , Westville	" " 1935
CLARENCE C. ANDREWS , Atlantic City	" " 1934

Committee on Publication

HENRY C. BARKHORN , <i>Chm.</i> , Newark	Term expires 1936
EDWARD J. ILL , Newark	" " 1934
LINN EMERSON , Orange	" " 1935
FREDERIC J. QUIGLEY	Ex-officio
J. BENNETT MORRISON	Ex-officio

Committee on Finance and Budget

HARRY R. NORTH , <i>Chm.</i> , Trenton	Term expires 1939
ALFRED STAHL	" " 1934
JAMES S. GREEN	" " 1935
HERSCHEL PETTIT	" " 1936
WILLIAM G. HERRMAN	" " 1937
WILLIAM J. SWEENEY	" " 1938

Committee on Program and Arrangements

WILLIAM J. CARRINGTON , <i>Chm.</i> , Atl. City	Term expires 1935
JOHN W. GRAY , Newark	" " 1934
WILLIAM D. OLMSTEAD , Atlantic City	" " 1936
FREDERIC J. QUIGLEY , Union City	Ex-officio
J. BENNETT MORRISON , Newark	Ex-officio

Committee on Honorary Membership

THOMAS W. HARVEY , <i>Chm.</i>	Term expires 1934
W. E. DARNALL	" " 1935
EPHRAIM R. MULFORD	" " 1936

Committee on Hospitals and Medical Education

HARRY H. SATCHWELL , <i>Chm.</i>	Term expires 1936
WILLIAM W. BROOKE	" " 1935
ARCANGELO LIVA	" " 1934
JOHN H. CARLISLE	STUART Z. HAWKES
CHARLES H. DE T. SHIVERS	CHARLES B. KELLEY
WILLIAM R. LITTLE	EARL H. SNAVELY
LOUIS A. PYLE	ELMER P. WEIGEL
DAN S. RENNEN	HUGH H. TYNDALL
J. VINCENT SMITH	

Committee on Medical Defense

C. C. BELING , <i>Chm.</i>	EDGAR A. ILL
JOHN C. MCCOY	WILLIAM J. ARLITZ
E. REISSMAN	

Committee on Insurance

FRANK W. PINNEO , <i>Chm.</i>	CHESTER I. ULMER
BARCLAY S. FUHRMANN	A. DUNBAR HUTCHINSON
EDMUND N. HUFF	WAYNE W. HALL
WARREN D. ROBBINS	

Welfare Committee

FREDERIC J. QUIGLEY , <i>Chm.</i>	Union City
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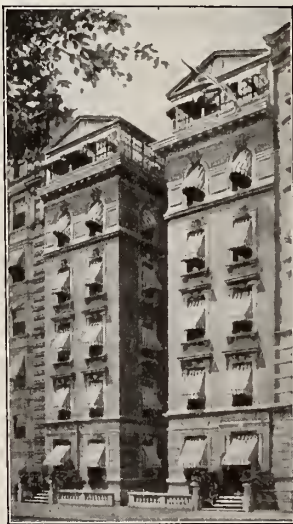
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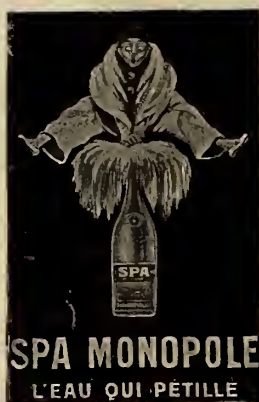
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APRIL, 1934

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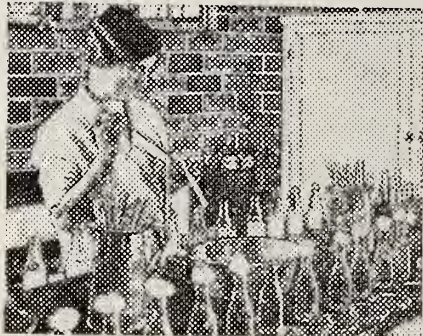
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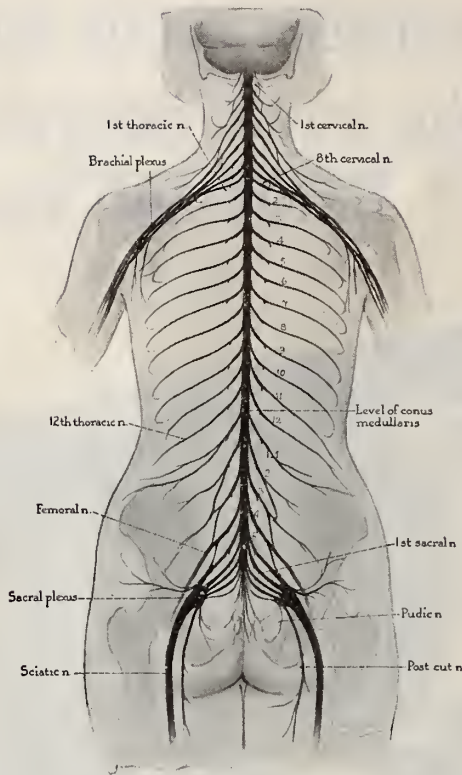
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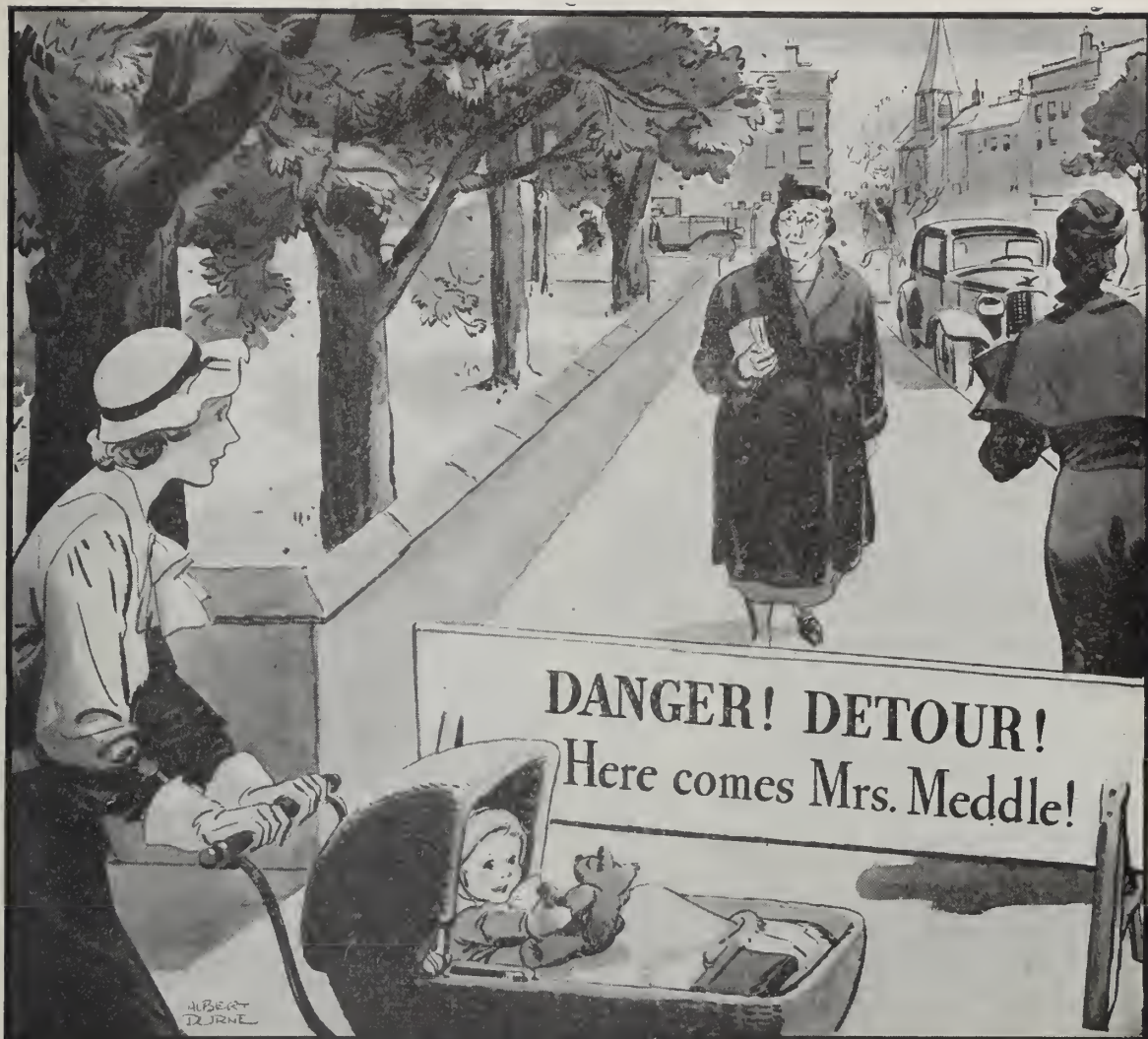
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"As to the kind of extra carbohydrate to be added, whether lactose or maltose, I believe dextri-maltose to be better in general in cases of fat indigestion infantile atrophy."—C. H. Dunn: *The Hygienic and Medical Treatment of Children*, Southworth Co., Troy, New York, 1917, V. 1, p. 418.

In the treatment of decomposition, "The period of repair may be shortened by giving suitable additional food; the best, probably, being buttermilk to which carefully regulated proportions of dextrin and maltose preparations or malt soup are added."—E. Feer: *Text-Book of Pediatrics*, J. B. Lippincott Co., Phila., 1922, p. 284.

In infantile atrophy, "The carbohydrate should be increased by gradual addition of dextrimaltose.

"Malt soup or dextrimaltose (Mead's) should be added in teaspoonful or more doses to each feeding until the point of carbohydrate tolerance is reached."—L. Fischer: *Diseases of Infancy and Childhood*, F. A. Davis Co., Phila., 1925, V. 1, p. 285.

In the case of a premature infant, "Dried milk with water was given, which later was changed to whole milk, 14 ounces; water, seven ounces, and dextri-maltose No. 1, one and one-half ounces. Seven feedings of three ounces each every three hours was given. The above feeding was retained. The infant gained eight ounces at the end of the first week."—L. Fischer: *Clinical notes in a series of premature infants*, *Arch. Pediat.* 44:227-231, April, 1927.

In the treatment of decomposition, "As a rule it is best to start with 2 to 2½ or 3 ounces of albumin milk to the pound weight in 24 hours; the sugar to be added is in the form of a maltose-dextrin mixture. One should never delay too long in adding this."—C. G. Grulee: *Infant Feeding*, W. B. Saunders Co., Phila., 1922, p. 265.

With reference to hypotrophy, "In mild cases, the addition of dextrimaltose instead of cane or milk sugar may be sufficient to obtain a gain in weight."—C. Herman: *The treatment of nutritional disorders in artificially-fed infants*, *New York M. J.* 114:158-160, August, 1921.

In athrepsia, "The carbohydrates are usually added in a slowly fermentable form, such as the maltose and dextrin compounds, which are usually started by the addition of four grams per kilogram (1/15 ounce per pound) and increased until eight grams or more per kilogram (¼ ounce per pound) of body weight are added."—J. H. Hess: *Feeding and the Nutritional Disorders in Infancy and Childhood*, F. A. Davis Co., Phila., 1928, p. 278.

Concerning the treatment of marasmus, "When the stools have become smooth and salve-like, carbohydrate, in the form of dextrimaltose, may be gradually added up to the limit of tolerance."—L. W. Hill: *Practical Infant Feeding*, W. B. Saunders Co., Phila., 1922, p. 281.

In the feeding of prematures, "As soon as there is a hesitation in the gain in weight, dextrimaltose No. 1 is substituted for the dextrose, in the same amount in the mixture, with almost invariably a gain in weight."—F. B. Jacobs: *Relation of irradiated food substances and ergosterol versus cod liver oil in childhood nutrition*, *Pennsylvania M. J.* 35:164-167, Dec., 1931.

"A spasmophilic baby on bottle feeding should receive a limited amount of milk—a pint, or at the most 24 ounces in the 24 hours—to which cereal gruel and some form of sugar is added, preferably one of the malt dextrin preparations; also the early addition of other foods than milk to the baby's diet."—M. Jampolis: *Infantile spasmophilia*, *Interstate M. J.* 25:652, Sept., 1918; *abst. Arch. Pediat.* 35:691, Nov., 1918.

In cases of malnutrition and indigestion, "The appetite improves rapidly, and the stools soon become normal in appearance, if the sugars are intelligently prescribed. By this I refer to proper proportions of dextrin and maltose. When there is a tendency to looseness, I have used the preparation known as 'dextri-maltose,' for the extra

carbohydrates; . . ."—M. Ladd: *Further experience with homogenized olive oil mixtures*, *Arch. Pediat.*, 33:501-512, July, 1916.

In pyloric stenosis, "With low dextrose tolerance, a maltose dextrin preparation may be added in whole or in part. Even where the dextrose is well tolerated and gain in weight has ceased, impetus to the weight intake may be given by the addition of a maltose dextrin preparation."—D. J. Levy: *Pyloric stenosis and pylorospasm of infancy with especial reference to medical treatment*, *J. Michigan St. M. S.*, 21:166-170, April, 1922.

With reference to the treatment of diarrhea, "After several days, 2% to 3% of a maltose-dextrin preparation may be added (Dextri-Maltose). This is preferable to the easily fermentable lactose or cane sugar."—F. Lust: *The Treatment of Children's Diseases*, J. B. Lippincott Co., Phila., 1930, p. 145.

In dyspepsia, "The carbohydrate must not be allowed to exceed 3 per cent. Dextri-maltose is the most suitable sugar."

In the treatment of decomposition atrophy, malnutrition, marasmus, ". . . when there has been obvious improvement, dextri-maltose is gradually increased from 3 to 5 per cent."—B. Myers: *The nutritional disturbances of infancy*, *Brit. M. J.*, 1:1079-1083, June 21, 1924.

"The treatment of artificially fed children in the first of these groups consists in putting them on a low fat dietary, and giving them carbohydrate in the form of one of the less fermentable sugars—e.g., dextrimaltose."—L. G. Parsons: Wasting disorders of early infancy, *Lancet*, 1:687-694, April 5, 1924.

In the milder cases of inanition, "Regulation of this disturbed organismal balance is obtained by the addition of carbohydrates, while fat and casein are reduced. For this purpose dextrimaltose and flour are better than the ordinary sugars, since they are more slowly absorbed and have greater efficacy in their powers of controlling the flora in the large intestine."—W. J. Pearson and H. G. Wyllie: *Recent Advances in Diseases of Children*, P. Blakiston's Son & Co., Phila., 1930, p. 116.

In intestinal intoxication, "I have had more experience with dried skimmed milk in which 2 to 5 per cent dextrimaltose, barley or rice flour has been cooked, and the mixture subsequently fermented by lactic acid bacilli or soured with lactic acid, than with any other food except protein milk."—G. F. Powers: *A comprehensive plan of treatment for the so-called intestinal intoxication of infants*, *Am. J. Dis. Child.*, 32:232-257, August, 1926.

Regarding the treatment of the marantic infant, "After the intolerance to sugar has been overcome a carbohydrate, preferably Dextri-maltose, may be added."—C. S. Rauce: *Diseases of Children*, Boericke & Tafel, Phila., 1922, p. 427.

In spasmophilia, "Dextri maltose is the best sugar to use in these cases, in the proportion of 6 to 8 per cent."—J. H. Reading, Jr.: *Spasmophilia*, *Hahneman*, Monthly, pp. 403-411, July, 1922.

In the treatment of atrophy, "If the baby continues to improve, the next step in the treatment is to add to the milk one of the less fermentable carbohydrates, such as dextrimaltose; . . ."—H. Thursfield and D. Paterson: *Diseases of Children*, William Wood & Co., 1929, p. 105.

"I also find dextri-maltose an excellent addition to albumin-milk when the first object of that food has been achieved and a gain in weight is desired, in this way I have succeeded in feeding albumin-milk far beyond the period usually advised, with highly gratifying results."—F. L. Wachenheim: *Infant-Feeding; Its Principles and Practice*, Lea & Febiger, Phila., 1915, p. 158.

"Dextri-maltose has been substituted for lactose not infrequently, when the tolerance for the latter continues low."—J. H. West: *Low fat, high starch evaporated milk feeding for the marasmic baby*, *Arch. Pediat.* 48:189-193, March, 1931.

"Malt sugar is indicated when others fail to produce a sufficient gain, or when malassimilation of fat is evident."—O. H. Wilson: *The role of carbohydrates in infant feeding*, *Southern M. J.* 11:177, March, 1918; *abst. Arch. Pediat.* 35:447, July, 1918.

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The leading editorial of the February issue of Colorado Medicine is on the subject of unethical advertising by professional groups. It says:

"To quote from Chapter XIV of our By-Laws: 'In the event of unethical conduct on the part of any group, clinic, or hospital staff the members thereof shall each be held culpable therefor, and summary action shall be required of constituent societies to punish such breaches of medical ethics on the parts of groups, clinics, or hospital staffs.'"

Since some institutions have advertised to give medical service, the Board of Councillors of the State Medical Society passed the following interpretive resolution:

"Resolved, that advertising to or solicitation of the laity, by any group, clinic, hospital, sanatorium or related institution; or by any corporation, association, society or other organization, educational, religious or otherwise, engaged in the care of the sick, except as authorized by the Council of this Society or the Board of Censors of the interested Constituent Society, shall hereafter be construed as equivalent to advertising and solicitation by the physicians employed by or associated in any professional capacity with the offending institution, and shall subject such physicians to discipline under the provisions of Chapter XIV of the By-Laws of this Society for breach of the Code of Ethics."

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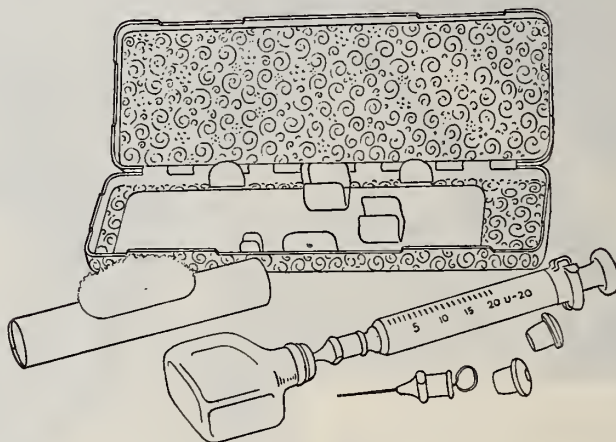
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THE JOURNAL
FRANK OVERTON, M.D., Dr. P.H.

OFFICES OF THE SOCIETY—137 EAST STATE STREET, TRENTON, N. J., TEL. 9330
EXECUTIVE SECRETARY—LEROY A. WILKES, M.D.

Each member of the State Society is entitled to receive a copy of THE JOURNAL every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.
Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.
Officers, Trustees, Councilors and Committees of the Society are listed on page xxii of the Advertising Section.

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APRIL, 1934

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EDITORIALS

The Doctors' Title Bill

Senate Bill No. 183, known as the "Doctors' Title Bill" which is now pending in the Legislature, and which would limit the title "doctor" to graduates in medicine and dentistry, was the subject of an exchange of letters between a member of the Woman's Auxiliary to the Medical Society of New Jersey and a member of the Senate of New Jersey. The correspondence was referred to Dr. Frederic J. Quigley, President of The Medical Society of New Jersey, whose answer to the Woman's Auxiliary member was as follows:

Union City, N. J., March 22, 1934.

My dear Mrs. ———:

Senator ——— contends that if dentists and veterinarians are not excluded from using the title "doctor", etc., neither should osteopaths be barred; and makes the point that, in order to obtain the obvious motive of the bill, we should go the whole way and abolish the term "doctor" except for those practicing medicine and surgery.

The word "doctor" is a Latin term meaning "one who is learned or a teacher". It has always been associated with the learned professions ever since it was first conferred in the

twelfth century in Bologna, Italy. The doctorate degrees were limited to the learned professions—theology, philosophy, law and medicine—but the only doctor with whom the people generally have come in contact has been the *doctor of medicine*; and the title is popularly taken to mean a *physician*. In fact, the first definition of a doctor in the Standard dictionary, is "A practitioner of medicine or surgery".

Former Governor Alfred E. Smith, several years ago, prior to signing an amendment to the Medical Practice Act in New York similar to the one we propose, trenchantly remarked: "*The term 'doctor' should be made to mean what the average every-day citizen expects it to mean—a person competent to treat sickness or accident in any shape, form, or manner.*"

We maintain that osteopaths and chiropractors using the term "doctor" masquerade as something which they are not. The public has the idea that osteopaths, chiropractors, chiropodists, and optometrists have perhaps taken a slightly different general course, qualifying them particularly as *specialists* in certain branches of medicine. As a matter of fact, they have had inferior educational training,

and have been licensed to practice a *limited field* or a *limited "system"*. We know that these cultists—osteopaths, chiropractors, etc.—constantly and persistently practice medicine *beyond the limits* of the acts under which they are licensed. They insist upon the right to use this title so as to delude the public into thinking them competent to practice medicine without limitation.

Illustrative of this is the requirement in the present Chiropractic Act, which makes it necessary for an applicant for licensure in New Jersey to have received the absurd degree "Doctor Surgeon Chiropractist". Graduates of probably the best school of chiropractic in the United States, which confers the degree of "Master Chiropractist" are, for this reason, barred from licensure in this State.

Now as to dentists and veterinarians: Dentistry is viewed as a specialty in the practice of medicine. The pre-educational requirements of dentists are identical with those of doctors of medicine. The course of the first two years in dentistry parallels that in medicine; in fact in many schools both classes of students attend the courses together. Dentists confine their practice *to dentistry*, and there is never any attempt by them to invade the general field of medicine and surgery. Universities have dental as well as medical colleges; no university has established a school of osteopathy or of chiropractic.

We see no good reason for interfering with veterinarians using this title, for they practice only *veterinary* medicine.

Holders of academic degrees such as D.D., LL.D., and Ph.D. do not hold themselves out as practitioners of medicine.

The sole purpose of this supplement—Senate 183—is to limit the use of the title "doc-

tor", by those treating human illnesses, to Doctors of Medicine and Doctors of Dental Surgery. That the limitation such as we propose does this, is attested by the experience of New York, where such a restriction has been in effect for several years. Authorities in New York State maintain that the limitation of the title "doctor" has been the most vital single factor in curtailing quackery in that State.

That the doctors' title bill is no new proposition is shown by the following extract from the first annual message by Governor George S. Silzer to the New Jersey Legislature on January 8, 1924:

"It is also suggested that the title 'doctor' should not be permitted to be used except by those who are licensed to practice medicine, surgery and dentistry in connection with the human body (including, of course, those who have purely honorary degrees)."

Governor Silzer also upheld a high standard of medical service by using the following argument in his message vetoing the chiropractic bill in 1924:

*"Too much care cannot be exercised in throwing protection around those who need medical care and attention. I do not think that this bill gives our people that protection." * * **

*"They (chiropractists) may use the word (doctor), and may become qualified by examination before a board of two chiropractists. There is already too much suffering and injury from the treatment of the human body by those unskilled and ignorant. * * * Our every effort should be to tighten the restrictions, rather than release them." * * **

You are at liberty to use this letter as you choose.

Yours sincerely,

FREDERIC J. QUIGLEY, President,
The Medical Society of New Jersey.

The House of Delegates

The 168th Annual Meeting of the Medical Society of New Jersey will open on June 5, 1934, in Haddon Hall, Atlantic City, with a session of the House of Delegates, whose members are elected by the twenty-one component

county medical societies. The object of the session is three-fold:

(1) To receive and consider the reports of the officers and committees of the state society on their activities during the past year.

(2) To act on the suggestions contained in the reports, and to establish the policies of the state and county societies for the coming year.

(3) To elect officers who shall carry out these policies.

Many of the delegates will have had experience as members of the House in former years, and a still larger number will have been chosen because they have had wide experience in their county societies. But there will be a responsibility on every delegate, new or old, to make a special preparation for the performance of his duties. His position is one of responsibility and trust, and his decisions and votes will have a direct effect on the scope and methods of the practice of medicine throughout the state.

The greater part of the business of the House of Delegates will be the consideration of the recommendations contained in the annual reports of the officers and committees. These will be published, so far as possible, in the May number of this Journal. The object of

the early preparation and publication of the reports is to make them available for *study* not only by the delegates, but also by all members of the county societies. A careful study of these reports by every delegate is essential for wise action by the House.

A member accepting the election as delegate imposes on himself an obligation to attend *all* sessions of the House. If he makes a serious preparation for his office, no substitute can perform its duties so well as he. If, in addition, he understands the special problems which concern the practitioners of medicine in his own community, his advice will be sought and heeded, and he will have the satisfaction of contributing to the progress of medicine throughout the state.

It is urged that each county society shall complete its full quota by the May meeting of delegates to represent it in the House of Delegates, and to complete the roll at an early date in order that those chosen may have time to prepare themselves for the intelligent discharge of their duties.

Adventuring in Medical Co-operation

The Emergency Relief Administration (E. R. A.) has afforded the medical profession the opportunity of adventure in a field of service in which *coöperation* is taking the place of *competition* among the several groups of workers. A practical system for giving medical care to indigents has been developed in New Jersey with startling suddenness under the pressure of necessity. The basic facts and needs, and the steps taken to meet them, may be stated as follows:

(1) An unusually large number of people are now, and have been for some time, in need of medical service for which they are unable to pay.

(2) This fact has caused many physicians to be called upon to furnish this service without remuneration for the past three or four years.

(3) There are three possible ways of providing medical service to indigents: (a) Unorganized individual charity care, the old system; (b) Organized coöperation between the medical society and relief agencies, the New Jersey

coöperative plan; (c) Governmental operation and control, the bureaucratic method.

(4) The physicians in New Jersey have so far responded nobly, and the load of work thrown upon them is increasing at a time when their professional incomes are greatly reduced.

(5) The governments, Federal and State, have authorized and established the Emergency Relief Administration, considering medical service to be as necessary as food, clothing, and shelter.

(6) The county medical societies have been offered the opportunity to enlist their members who signify their willingness to abide by the regulations established by the E. R. A.

(7) The alternative in counties where the physicians refuse to coöperate with the plan approved by the State Medical Society and the E. R. A. is either governmental operation and control through contract practice, or unorganized volunteer service of individual physicians.

(8) The Emergency Relief Administration offers to aid the physicians in bearing their

load by paying fixed sums for service they render to the indigents authorized to receive medical treatment. These payments are not intended to represent full value received, for this would be impossible.

(9) The Medical Society of New Jersey has officially accepted this offer, and mutual principles and policies to guide both parties in their plans for coöperation have been evolved and approved by both organizations. The ways and means to be used are left to the County E. R. A. Director and the Medical Relief Advisory Committee in each county medical society.

(10) There are many difficulties to be met, the majority of which can be overcome through the observance of goodwill on both sides.

Fourteen counties have signed and returned the "Uniform agreements" as requested. These agreements have been approved and the funds are now available for payment of the established fees for medical relief given by physicians whose names appear upon the list approved by the Medical Relief Advisory Committee appointed by the medical society in his county.

Any regularly licensed physician in New Jersey may have his name placed upon the list upon application to the Medical Relief Advisory Committee in his county, but names can be removed at any time for cause. Only "authorized" cases will be paid for by the E. R. A.

After February 15, no E. R. A. funds will be available for Medical Relief services under the agreement made unless a signed uniform agreement is approved by the E. R. A. officials in Newark (20 Washington Avenue).

Counties which had signed an agreement *prior* to the one now required must submit a *new* agreement on the unified form now used, copies of which will be sent on request to the E. R. A. or to the Medical Society headquarters (137 East State Street, Trenton).

An outstanding difficulty has been the law prohibiting physicians who hold official positions under a governmental agency from receiving E. R. A. fees for services rendered to indigents. This law was a most grave handicap in rural areas where school physicians especially are numerous and there are not a sufficient number of eligible practitioners

available to give the proper E. R. A. service. This difficulty was removed by a new law, but complications arose necessitating further enactment. (See page 232.)

Another difficulty was the expansion of the facilities which are usually provided to care for the *chronic* indigents who are always with us, especially in large cities. "Free clinics" and "city physicians" are overworked and compete with the private physicians working under the E. R. A. agreement. This results in a poor grade of service to the sick, with lowered morale in both the patient and the physician.

The medical profession in the United States is engaging in a new adventure in coöperative effort, and New Jersey is leading the way. For many physicians this is a new experience in "team work", where the individual is to some extent obscured by the team, and where rules and regulations, supervision and schedules, reports, and vouchers are involved. These at first seem formidable obstacles, but they are inherent in economical and effective public services. Medical service for *all* the people is the demand of the times; and the Medical Society of New Jersey will meet that demand on a fair basis.

Records and Reports—The administrators of the E. R. A. very properly require that each doctor submitting a bill for treatment shall include a certain amount of information regarding each case. This record is necessary in order to enable the governmental officials to account for the funds which they disburse. Physicians must give attention to the business and economic phases of their cases just as they must keep accurate medical histories of their patients in hospitals. But whereas the lay employees in a hospital relieve the doctor of many of his clerical duties, the family practitioner is his own clerk; and if he is a poor clerk to himself, he is equally unsatisfactory to the E. R. A. administrators.

Transactions involved in both professional practice and the business providing medical services *can* and *should* be kept in medical hands, as they will be if the physicians co-operate in the proper spirit with other community agencies.

LE ROY A. WILKES,
Executive Secretary.

Surveys of Local Conditions

Guest speakers at Medical Society meetings advise the members to apply the general principles of medical economics and administration in solving their local problems. This is a euphemistic way of suggesting to the doctors that they give diligent attention to the general principles recognized by leaders everywhere and to substitute a detailed survey of local conditions for personal impressions gained from isolated experiences.

When a survey is discussed, some speakers are likely to claim that local conditions are entirely unique, and that there are insuperable obstacles to the application of the general principles that apply elsewhere. It is true that each community has its own peculiar medical conditions and health problems; but these vary in *degree* rather than *kind*.

A doctor's attitude toward the newer methods of medical administration depends largely upon his predominant temperament. Nearly every doctor is a conservative by nature and by training, but every medical society contains a few men of vision who can estimate community needs which are not now met, and who are willing to plan a medical service that will be satisfactory to both the people and the physicians. These are local leaders whom the Medical Society of New Jersey is seeking. The efficiency and adaptability of their plans will depend on the scope and accuracy of their knowledge of local conditions. This knowledge can best be gained by a survey of the field made under the auspices of the Medical Society.

The Medical Survey—The medical survey is a common ground on which all doctors can meet. Every doctor will approve a survey of the financial status of patients in the free wards of his local hospital, because this is a fact-finding process. Every doctor *thinks* that he knows how much free medical care is abused, but facts disclosed in a survey will show the exact extent of the abuses of medical charity. A fact-finding survey is a necessary preliminary to constructive action.

The steps to be taken in promoting any new method of delivering medical service in a com-

munity are the same as those which are followed by the doctor in designing a method of treatment suitable for a new patient.

First, there is the *examination* or survey of the patient in order to determine such basic facts as his temperature and the condition of his lungs and heart. Even if physicians may differ in regard to these basic conditions when they merely look at a patient, there will be a remarkable agreement among them when they apply instruments of precision and their trained senses and faculties in making an accurate examination of his organs and functions. It is equally true that the physicians of a town or county making an actual survey will agree on the facilities that are available for giving medical service to the poor in that community.

The second step is that of formulating a *diagnosis* based on the findings of the examination. The great majority of practicing physicians will agree on the diagnosis of the condition of a patient whom they have examined. They will be equally agreed in their diagnosis of conditions in a community which they have surveyed.

The third step is the application of the proper *treatment* for the condition which has been diagnosed. Here divergences of opinion and practice may arise because of the individualities among the physicians, as well as among the patients. Still more marked will be the divergences of opinion regarding the treatment of community conditions which are disclosed by a survey. However, just as physicians agree on a diagnosis and plan of treatment based on the examination of the patient, so they will agree on the proper method of treating a condition of the community after a survey has been made.

Serious disagreements among physicians over private patients are becoming rare since the custom of making careful examinations of the patient has been established. A similar unanimity in community health services will be achieved when the doctors adopt the practice of supporting an accurate survey of the medical needs of their local community as a preliminary step to prescribing a new method or system of service.

The Hospital and the Physician

In times past the individual lived in constant fear of disease and death. His life was overwhelmed with ignorance, and he believed that he felt or saw sinister meanings in every move of nature or the acts of individuals. Superstition, witchcraft, quackery, the voodoo and all manner of distorted notions about life and sickness were prevalent everywhere.

Today the individual quietly contemplates death as a natural sequence to life. He has an understanding of most of the diseases and confidence in the weapons with which to stay the hand of infirmity and the Scythe of Time. Advancing years he cannot stop, but at least the accidents and infections which harass and destroy him are known, and are yielding to his control. Knowledge stands beside the wavering wayfarer along life's pathway to support and encourage him and calm his useless fears. This comfort and calmness of mind, and this assurance of a peaceful life are the direct results of medical science, and of medical service given by physicians and members of allied professions.

To apply this knowledge efficiently, institutions are needed in which all the aids for protection and care, and all the weapons for the eradication of disease and infirmity shall be available. This strong, right hand of the physician is the *hospital*. The public realizes this natural relationship and has provided the equipment and the buildings wherein all may have the essential satisfaction of a fair and honest battle with disease and death. The objects of the hospital are to cure some; to relieve many; and to comfort all who come into its wards.

The services of the hospital may be needed some day by anyone in this community whether he be rich or poor. The hospital is a public institution at the service of all, like the court house, the post office, or the school. The hos-

pital, whether pay or free, is fulfilling a distinct and vital need in the community. The professional staff and the maintenance workers who labor unselfishly in its behalf render a fine and noble service to all. It is an ideal example of groups of citizens coöperating for the single purpose of delivering medical services to the sick. No other group of workers excel the members of a hospital staff in their diversity and yet harmony of action, and in the efficiency of their labors.

Every member of the staff of a hospital is actuated by an intense desire to approach the ideal standard of accomplishment, each in his own special assignment of duty. Upon the Board of Trustees rests the reputation of the hospital for the adequacy and safety of its physical plant, the efficiency of its equipment, the giving of the most for the least return, its general performance of a great public duty, and its thoughtful and sound stewardship of the gifts from the strong to the less fortunate. The trustees have the coveted opportunity to pursue and achieve the ideal in business management.

The hospital's reputation for comfort and care depends on the efficient training of the nurses and on their skill and devotion. Its reputation for mercy depends on the general atmosphere of kindness created by its administrative staff. Here is a great chance to develop the ideal of character and altruism.

The hospital's reputation for relief and cure of suffering humanity, which is the only reason for its existence, depends upon the conscientious exercise of the highest scientific knowledge and skill by the physicians. On the continued pursuit of that ideal by its physicians the good name of the hospital finally rests.

EDWARD W. SPRAGUE.

Water Purity

The peculiar seasonal prevalence of disease has almost disappeared with the application of scientific measures directed against their immediate causes, which are largely independent of months and the weather.

Summer complaints are no longer on the list of common diseases of children; and the warmest months are now among the most healthful for babies. Autumn no longer brings its fever and ague since the elimination of mosquitoes, whose hordes reached their peak after a summer of uncontrolled breeding.

Winter has ceased to be the special season of colds and pneumonias; and the greatest epidemic of this disease ever known occurred in 1918 during a spell of exceptionally balmy weather in October.

Spring fever is now considered a joke by those who have never experienced the peculiar form of anemia and languidness which always disappeared with the addition of greens and milk to the winter diet of meal and salt meat. But there still exists a widespread threat to health which is directly dependent on a seasonal cause—that of the pollution of water supplies by the floods of Spring.

Warm weather will always continue to melt the winter's snow and ice on the fields and hill-sides. Streams of surface water that are unknown during the rest of the year will carry pollution from barnyards and out-houses into brooks and rivers, and the wells of private

houses. The swiftness of the flow, the agitation of the water, and the prevailing clouds in the sky prevent the purifying processes which are efficient under the conditions which prevail during ten months of the year.

The threat from polluted water supplies is two-fold: (1) That from living bacteria of disease; and (2) that from soluble toxins from diseased and decaying material.

Bacteria are slow in their action and remain in the body for a week or two before they produce sickness; but the disease will be persistent and the recovery slow. On the other hand, toxins will produce diarrhea within twenty-four hours, and recovery will usually occur within two or three days.

The practical point for physicians to consider is that a group of diarrhea cases simultaneously developed is suggestive of a water-borne infection.

When pollution of a water supply is suspected, the physician can secure prompt assistance from the Department of Health: first, from the local health officer; second, from the district health officer; and third, from the State Department of Health. A request made by the family physician to the local health officer will bring all the facilities of the State Department of Health for making inspections or *diagnoses*; and also for instituting protective and curative measures, or the *treatment* of the conditions.

Leaders and Key Men

Every society has members who are "key men" in any specific situation. The strength of a key man will lie in his personal relations with those whose support the society needs.

A key man is especially valuable in medical legislation. Every member of the legislature has some doctor on his list of close friends. A word from that doctor is mightier than a resolution by the medical society.

An encouraging characteristic of the key man is his response to the compliment implied

in his being recognized as a man of power. Although he may not be prominent in his medical society, yet he is pleased at being asked to render an essential service to his colleagues, and to the community.

Key men exist in every community, but they must be sought out. A large degree of the success of a leader in a medical society will depend on his discovery of the key men to be his spokesman to those who are essential to the success of his plans.

ORIGINAL ARTICLES

GAS BACILLUS INFECTION

By EDWARD M. FINESILVER, M.D., Newark, N. J.

Gas bacillus infection has been known from the time of Hippocrates, and has been described by military surgeons from the time of the Crimean War to the World War. It is often seen in civil life, especially after compound fractures. It may occur, however, in a great number of other conditions.

Gas gangrene of the urinary tract occurred in this hospital as follows:

S. G., male, age 60, admitted May 7, 1930, with a diagnosis of prostatic hypertrophy. On May 24 a suprapubic cystotomy was done without difficulty. Twenty-four hours after the operation the temperature was 102°. The patient developed a crepitant swelling in the subcutaneous tissues of his lower abdomen. The temperature went to 103½°, and 48 hours after the operation he died from the gas bacillus infection. Smears and cultures from the wound were positive for bacillus welchii and hemolytic streptococci. A. Weiser describes another case in a man of 60 with hematuria. Examination revealed the presence of gas in the bladder. At operation smears from the urethra and bladder showed a Gram-positive plump rod which on cultivation was identified as bacillus welchii.

The following case admitted to this hospital was infected following a hypodermic injection:

A. G., male, age 48, salesman, admitted September 5, 1928, in an almost moribund condition with the history that he had developed an infection in his arm at the site of a hypodermic injection for asthma only 24 hours before. At operation, which was done by Dr. Danzis immediately without the necessity of anesthesia, he was found to have a crepitant swelling of his entire arm, the axilla and the pectoral region, with many cutaneous blebs. The involved area was opened widely and a foul smelling gas escaped from the multiple incision. He died four hours after admission.

ETIOLOGY

Gas gangrene is caused primarily by a group of anaerobic organisms which grow best in

muscle tissue. One would expect, therefore, that this disease will develop in such wounds as have a diminished oxygen supply and injury or exposure of muscle. Gas bacillus infection takes place most frequently in deep wounds where the depth excludes oxygen. Lacerated wounds and crushing wounds, hematomata and compound fractures offer, particularly, favorable sites for the development of gas gangrene. Two important conditions, devitalized tissue and absence of oxygen favor the rapid growth of gas bacilli. Lack of oxygen in tissues damaged by trauma or by interference with the blood supply favor the rapid growth of the organisms with gas formation and toxin production. Gas-bacillus infection is seen most frequently in wounds about the extremities. This has been explained on the basis of the more frequent contamination with dirt of these parts and also by the poorer collateral circulation of the limbs. Orens feels that the circumferential swelling acts as a tourniquet to produce further ischemia which aids the process.

It is not difficult to appreciate the occurrence of gas bacillus infection in gangrenous appendicitis, acute intestinal obstruction, and peritonitis with ileus when we realize that bacillus welchii and vibrio septique naturally inhabit the alimentary canal of man. It is believed that bacillus welchii as it normally exists in the small intestine multiplies rapidly in these patients suffering from acute intestinal obstruction and peritonitis with ileus. A normal loop of intestine becomes subject to anaerobic invasion only when its circulation is disturbed as in ileus or gangrenous appendicitis.

Bacillus welchii is credited with causing about 75 per cent of the cases of gas gangrene.

Bull and Pritchett in 1917 developed an antitoxin for this organism with the hope that the problem of treatment and the prevention of gas bacillus infection would be solved by this antitoxin. It was taken to France where it proved to be a failure. French bacteriologists, the most prominent being Weinberg and Seguin, studied the wounds of gangrene and learned that the bacillus aerogenes capsulatus was in association with other bacteria. The following organisms were then identified as co-existing etiological factors of prime import in the causation of gas bacillus infection:

- (a) Pasteur's vibron septique.
- (b) Bacillus oedematiens.
- (c) Bacillus histolyticus of Weinberg and Seguin played an important rôle in gas infections by inducing severe lesions of the muscles and blood vessels, and by favoring the development of other pathogenic anaerobes.
- (d) Bacillus Sordelli. In 1922 Sordelli described a new toxin-producing anaerobe isolated from gas gangrene.

Thus it appears that the combined efforts of symbiosis of several species of bacteria are required to produce gas gangrene. Tissier showed in his experiments that gas forming organisms in themselves had little power to cause gas gangrene, but when affiliated with other organisms the typical disease was quickly produced. The aerobic associates probably function by utilizing the available oxygen in the tissues and also by diminishing the patient's resistance. Weinberg isolated two varieties of gas gangrene bacilli, the saccharolytic and the proteolytic groups. The saccharolytic group metabolizes sugars and fats of the muscles, resulting in the forming of butyric acid. The presence of this group of organisms in the wound is characterized by the sour odor and the brick-red color of the muscle. This partial destruction of the muscle tissue prepares the way for the proteolytic group to complete the destruction. Their presence is characterized by the odor of putrefaction which is typical for gas bacillus infection. During the growth in the tissues, the bacillus welchii elaborate a hemolytic toxin which produces further local destruction of tissue and by absorption remote constitutional symptoms.

THE HABITAT OF GAS BACILLUS

It is a fact that gas bacilli can exist in the body for a considerable period without gas formation but under certain conditions quickly assume the capacity to form gas and destroy tissue. Bacillus welchii and vibron septique naturally inhabit the alimentary canal of man and animals, especially sheep. Gage has observed gas bacilli in wool and is of the opinion that these organisms are found especially in woolen goods. He not only found gas bacilli in the wool pads interposed between powder and shot in ordinary bullets, but also grew them in cultures taken from woolen clothes just returned freshly pressed from the tailor shop and even in samples of new cloth.

A very interesting observation made by Maes is that gas gangrene has a seasonal incidence in the South. It occurred only at a certain time of the year in people who were wearing woolen clothing at the time they were injured. In the summer, when linen clothes are worn, he has never seen a patient afflicted with gas gangrene who was hurt while dressed in linens; always it has been woolen clothing. Maes lost one patient from gas bacillus infection following a hypodermic injection and another from an infected burn in which the blister broke and the patient was between woolen blankets. In both instances he cultured the wool from the blankets and in both instances recovered the gas bacillus.

CLINICAL DIAGNOSIS

The early diagnosis of gas gangrene is of prime importance. The diagnosis is usually not difficult provided its possibility is constantly kept in mind. It should always be kept in mind when there is a deep lacerated or contused wound of the extremities, when there is a compound fracture, foreign body, or an impairment of the blood supply. Those cases in which there are pelvic or abdominal injuries, gangrenous appendicitis, intestinal obstruction, and peritonitis with ileus, especially should be regarded with suspicion.

The important sign of gas gangrene is, of course, crepitation in the tissues due to the presence of gas. Tenopyr calls attention to two suggestive symptoms that appear early. The first is pain within 36-48 hours becoming progressively worse and disproportionate to

the amount of injury; and secondly, the acuteness of intellect displayed by the patient. Euphoria is frequently a symptom in gas gangrene. Patients with a temperature of 104 degrees and in toxemia say they never felt better in their lives. This feeling of euphoria persists almost to death. It has been commonly observed how often the first symptom of gas gangrene is a pulse rate higher than should be expected from the patient's general condition; instead of 80 or 90 to the minute it is found to be 100 or 120; and the white blood cells range from 15,000 to 20,000. A loss of blood leading to shock and any constitutional disease tending to impair the blood supply to the part, such as diabetes or arterial disease, are predisposing factors. Such a combination of symptoms should lead to a very careful inspection of the wound when any of the following signs may be elicited: great tenseness of the skin with crepitation, with alternating khaki color of the anemic skin, and discolored reddish black patches and blebs. The area is at first localized and accompanied by inflammation and swelling. If an open wound is present, a foul smell, "mousy" or "rotten meat" odor, may be observed. Exquisite tenderness, a tympanitic note and a brownish-yellow evil-smelling discharge from the wound are also present. Familiarity with these features, notably the striking rise in the pulse rate out of proportion to the temperature, the severe local pain, the toxicity, and the unusual acuteness of intellect will bring these cases under treatment early enough for some chance of ultimate cure.

The affected muscle appears dull, opaque, and of a brick red color resembling cooked meat. At this stage the muscle is dead, it does not contract on stimulation nor does it bleed when incised. Later it becomes softer and gelatinous; and its color changes to green, brown or black. With the local process under way, gas gangrene rapidly produces a severe systemic reaction. Acidosis is present, the patient appears gravely ill, has an anxious expression, and there are the usual signs of shock. Unless prompt treatment is instituted, radical amputation becomes necessary to save life and in the more severe case death may soon follow. The importance of early recognition cannot be emphasized too strongly.

X-RAY DIAGNOSIS

The clinical diagnosis may be confirmed by x-ray, and by culture of the organisms. Rhinehart made an exhaustive study of air and gas in the soft tissues. The presence of air in wounds caused by deep lacerations into the underlying soft tissues is of minor importance, but the detection of gas caused by infection of anaerobic organisms is often of major clinical significance. Air in the soft tissues causes little discomfort and practically no untoward symptoms. Even the larger amounts resulting from a punctured lung occasions relatively little discomfort. These radiolucent shadows decrease rapidly in size and soon disappear. The earlier the diagnosis and the sooner treatment is instituted in gas gangrene, the better the chance for saving the patient from mutilating operations and the lowering of mortality. The detection of gas in the soft tissues shown by its shadow on roentgenograms is the earliest positive sign of infection with gas producing organisms.

The production of gas follows soon after the infection begins. The bubbles of gas cause characteristic dark or black oval, round, or irregular shadows around the wound of entrance. Larger accumulations have a spongy or reticular arrangement, many of the bubbles showing as clearly defined dark or black spots on the films. In the other, thin layers and streaks of gas show very distinctly, accurately outlining the direction of the muscle fibers. Rhinehart reporting on a series of 30 cases compared the clinical method of diagnosis with the x-ray method and found an average of 50½ hours for clinical diagnosis with 18½ hours by the x-ray method, an average of more than 30 hours in favor of roentgenographic diagnosis. In a condition that progresses as rapidly and is as serious as gas bacillus infection, an average delay of over 30 hours in the recognition of the condition and the institution of treatment, should be reflected in the mortality; and so we find that in 19 cases diagnosed clinically, the mortality was over 50% and in 11 cases diagnosed by x-ray it was only 18%. The differential diagnosis between gas shadows from infection and from air depends upon a re-examination after a short period of

about 6-8 hours. In that time if gas infection is present there will be an extension of the involvement; if the radiolucent shadows are caused by air, the involvement will be stationary or will regress.

BACTERIOLOGICAL DIAGNOSIS

A very easy cultural procedure was established during the War for rapid detection of the gas bacillus. Tubes of litmus milk recently boiled to drive off the residual oxygen were inoculated with swabs from the wound and incubated at 37 degrees C. There occurs within a few hours an acid clot torn by gas, and smears from it contain the Gram-positive bacillus welchii. Another quick cultural method is carried out as follows: Some of the necrotic tissue should be recovered directly from the localized area either by means of an aspirator or swab. This should be inoculated into freshly prepared Hibler medium or alkaline meat extract broth, with a content of 1% dextrose. The medium is then covered by a layer of liquid petrolatum. After 6-8 hours incubation, the appearance of gas bubbles point to the presence of anaerobic gas-producing organisms.

Tenopyr recommends a very simple procedure for the early detection of the presence of anaerobes. He places a portion of the macerated tissue into a test tube and covers it with melted agar. If anaerobes are present, gas bubbles will be seen after a few hours incubation.

TREATMENT

If we are to decrease the incidence of gas bacillus infection, we must always keep in mind the possibility of its development, and do all in our power to prevent its occurrence. It should be thought of and watched for in all cases of severely lacerated wounds, particularly those of the extremities. In crushing injuries, gunshot wounds and compound fractures, gas gangrene antitoxin is injected as a specific prophylactic treatment for all potential cases of gas gangrene infection. The indications for the prophylactic use of gas gangrene antitoxin are also those which require tetanus antitoxin. Since bacillus perfringens (welchii) and vibron septique are credited with causing

about 80 per cent of the cases of gas gangrene, Tetanus-Gas Gangrene Antitoxin is supplied in a syringe containing one prophylactic dose as follows:

1500 Units Tetanus Antitoxin

1000 Units Perfringens Antitoxin

10 Units Vibron Septique Antitoxin

Tetanus-gas gangrene antitoxin should be injected subcutaneously if the injection is given within 12 hours of the injury. If a greater time has elapsed the intramuscular route is preferable because this affords more rapid absorption. If the wound is extensive and contaminated with foreign bodies such as street dirt, shreds of woolen clothing, or if prophylaxis has been delayed, 2 or more prophylactic doses should be injected. In case there is still a possibility of infection, the prophylactic dose should be repeated in 5-7 days.

In cases of amputation for arterial disease, particularly in the presence of diabetes, it is wise to give the preventive dose of serum as part of the routine preparation of the patient. The prophylactic dose of this serum seems to be of great value in reducing the morbidity. In the German army, in 1200 wounded soldiers from two divisions, one of which had received prophylactic injections and one of which had not, the gas gangrene morbidity in the first group was 0.3 per cent while in the second it was 3 per cent. Similarly Rumpel subsequently reported that in the division which had previously been given prophylactic serum injections the morbidity dropped to 0.6 per cent whereas in the division not so treated the morbidity remained at 3 per cent. During the World War the use of antitoxin as a prophylactic measure against gas gangrene in the severely wounded is said to have brought about a lowered incidence of the disease from about 7 per cent to 1 per cent at the close of the war.

No set rules can be laid down for the treatment of these wounds. The surgeon will plan his course according to the type of injury, the tissue involved, and the contamination. The consensus of surgical opinion is that in order to minimize the chance of infection by anaerobic bacilli, it is of the utmost importance to inspect the wound area at frequent intervals.

to excise all crushed and devitalized tissue and to remove all foreign bodies insofar as is possible. It is important to direct attention to other means of preventing the development of gas gangrene. Shock must be energetically combated and the tendency to acidosis controlled. Spinal anesthesia is the method of choice since ether tends to produce acidosis, and so, finally develop gas gangrene infection. This was especially true in the case which we are reporting. Three spinal anesthetics were given during the treatment, with no apparent ill effects. Without spinal anesthesia we do not think we would have had such a favorable result. And finally in cases of anoxemia of the tissues due to a pre-existing arterial disease the use of a tourniquet should be interdicted as tending to further impair the nutrition of the tissue. As soon as suspicion of gas bacillus infection is aroused prompt, multiple, long incisions through the skin, fascia and muscles should be made in order to promote drainage and aeration and prevent ischemia. If the muscle shows the characteristic brick red (in later stages greenish) color, swelling, and lack of contractility, it should be freely excised or the entire muscle group removed.

Chemical agents that are used in conjunction with surgery in the treatment of gas gangrene are hydrogen peroxide, potassium permanganate and Dakin's solution. They are recommended in the belief that their power of oxidation would help check the infection. Dakin's solution is quite useful in ridding wounds of slough and cleaning them out while the peroxide and permanganate aid in the oxygenation of the tissues. Taylor demonstrated that in vitro a 1 per cent solution of quinine sulphate has a marked bactericidal effect on the gas bacilli and so Pilcher employed this solution with considerable satisfaction to himself, but it does not appear to have received general approval. The involved parts and the general progress should be watched diligently. Upon the appearance of the first signs of extension of the process, either local or constitutional, further debridement should be done, or better, high amputation. Whether after debridement or amputation, particular care must be taken to permit free access of air to the wound. After debridement and free incisions, the wound

should be left open for drainage and exposure to the air. Packing of the wound interferes with drainage and aeration.

SEROTHERAPY

Serotherapy with polyvalent anti-gas gangrene serum is now considered a most important adjunct to surgery in the treatment of gas bacillus infection. It should be used early and freely as a specific curative agent. It must be borne in mind, however, that the use of this antitoxin is only supplementary because surgical treatment is still of the greatest importance. Antitoxin should never be used as a substitute for surgery.

Larson and Pulford found their results very gratifying in seven cases, controlling anaerobic infection so that there was only one amputation and no deaths. Vincent reported that the antitoxin treatment of gas gangrene wounds reduces the mortality from 67 per cent to 15 per cent. In this country until recently, polyvalent serum was not obtainable and the results obtained from the use of the simple perfringens antitoxin were for the most part unsatisfactory. The individual anti-serum produced for one type of organism was quite powerless to effect the growth of the other organisms found in gas infected wounds.

In our case, we used the polyvalent gas gangrene antitoxin of Lederle. It is supplied in a vial containing:

- 10,000 units of perfringens antitoxin,
- 10,000 units of vibron septique antitoxin,
- 200 units of oedematiens antitoxin,
- 200 units of Sordelli antitoxin,
- 25 units of histolyticus antitoxin.

This combination contains antitoxins specific for all the toxin-producing, spore-forming anaerobes now credited with causing gas gangrene in man. For the curative treatment of gas gangrene, an initial dose of from one to four vials should be administered intravenously. The extent of the involved area, the length of time the injury has existed, and the apparent degree of intoxication all must be given consideration in deciding upon the dosage of antitoxin to be used. It is desirable to administer sufficient antitoxin in the first treatment to overcome the toxemia. If the condition of the patient indicates that this has not

been achieved, supplementary injections should be given in four to six hours or as soon as they are warranted by the symptoms. Supplementary injections of antitoxin intramuscularly in the vicinity of the wound may at times be advisable. Until improvement is evident, all injections of antitoxin should be made intravenously to obtain the best results.

The experience of the French surgeons in the World War with a polyvalent gas bacillus serum was so satisfactory that they used it with success as a prophylaxis as well as treatment in peritoneal infections and intestinal obstruction. The bacillus welchii proliferate in the intestines of patients with obstruction and peritonitis, and are a factor in their toxemia. The use of the serum in these cases has a scientific basis.

CASE REPORT

B. B., male, laborer, age 48, admitted December 16, 1930, with the history that he had received a crushing injury to the right foot and leg on November 26, 1930, about three weeks before admission. His right foot and leg revealed an extensive area of ulceration and gangrene over the internal malleolus extending over the heel into the sole of the foot and up towards the calf. There was an obvious compound fracture of the internal malleolus and bones of the foot. The plantar surface of the foot showed an extensive ulceration, the edges of which were greenish black in color, the muscles and tendons around the ankle and foot were exposed. There was a foul smelling yellowish-brown discharge exuding from the wound and marked crepitation in the subcutaneous tissues. The x-ray showed fractures of the astragalus and scaphoid bones.

A few hours after admission the patient was given a vial of gas gangrene antitoxin intravenously and the right leg was amputated below the knee. Three injections of antitoxin were given on the next three days.

On December 21, four days after the operation, he began to complain of pain in the wound and the pulse went up to 120 with a moderate rise in temperature. The stump showed a foul smelling discharge with crepitation, and here and there a dark colored cutaneous bleb. Direct smears from the wound revealed gram-positive plump rods with spores characteristic of the gas bacilli. A modified guillotine amputation was quickly done at the upper third of the thigh under spinal anesthesia and the wound closed loosely with two silk-worm gut sutures. Immediately following the operation he was given two more vials of gas gangrene antitoxin by the intravenous route. On December 22, the day after the second operation, he was again resting comfortably with no complaints. He appeared anemic and his hemoglobin was found to be 40 per cent. A direct transfusion of 600 cc. of whole blood was done and he was given also another vial of

gas gangrene antitoxin. On December 23 the patient's pulse and temperature again began to rise. He complained of pain in the thigh stump and inspection revealed a foul smelling discharge with crepitation and a dark patch about the size of a silver dollar on the upper skin flap. Direct smears from the wound again showed the presence of the anaerobic bacilli. With the patient in his bed and under gas oxygen anesthesia, the stump was widely opened with long longitudinal incisions through the skin and fascia, laying bare the muscles underneath. Irrigations of peroxide and potassium permanganate were then started and the patient given two more vials of gas gangrene antitoxin intravenously.

On December 24, 1930, the day after the third operation, the patient's temperature and pulse began to come down. He had very little pain in the wound. Alternating compresses of hydrogen peroxide and strong permanganate were continued, and the patient was given another intravenous injection of the antitoxin. On the 25th, improvement continued, the wound now looked clean and there was no odor or discharge. On this day he was given his last (eleventh) intravenous injection of the gas gangrene antitoxin. Permanganate and peroxide irrigations and compresses were continued until the 29th and smears taken for the past four days were negative and clinically there were no signs of gas bacillus infection in the wound. A Carrel-Dakin dressing was then instituted for several days and on January 7, 1931, the progress note reads:

"General condition of the patient extremely satisfactory. All vital signs normal. Granulations are healthy and clinically there is no sign of any infection. Smears taken from the wound are negative for bacilli and cocci."

Dakin irrigations were discontinued and warm boric acid compresses begun in preparation for a plastic operation to close the stump. On January 12, under spinal anesthesia, a plastic closure of the stump was done. The excess granulation tissue was cut away, the skin edges were trimmed, and the flaps loosened from the muscle and fascia. After several silver wire retention sutures were placed, the skin edges were accurately approximated with on-end mattress sutures (Staige Davis) of fine black silk. A small Dakin tube was placed through and through in the subcutaneous tissue for drainage. Convalescence from this last operation was satisfactory; the wound healed per primam, and the patient was discharged from the hospital on February 2, 1931.

Later, after the stump had shrunk to the size which would permit the fitting of an artificial leg, he received his permanent disability award from the Compensation Court in a lump sum and went happily on his way back to Portugal.

In summary, then, a Portuguese laborer with gas gangrene infection came under our care three weeks after a crushing injury to his right foot and leg. A successful outcome in this case was obtained only after a blood transfusion, eleven intravenous injections of polyvalent gas gangrene antitoxin, a nitrous oxide and three spinal anesthetics, two amputations, and a plastic reconstruction of the thigh stump.

AVERTIN RECTAL NARCOSIS IN OTOLARYNGOLOGY

By V. E. JOHNSON, M.D., F.A.C.S., Atlantic City, N. J.

During the past seven or eight years we have been very much interested in the anesthesia problem as applied to general surgery, and during that time there has developed a widespread interest in the field of anesthesia. We have not been entirely satisfied with ether as a general anesthetic and neither has the public. We have realized that we best serve our patients and ourselves by trying to choose a particular anesthetic for a given patient and his particular disease. Nitrous oxide, ethylene, ether, avertin, local and spinal anesthetics all have their particular uses, but should be used with discretion and thereby eliminate the routine use of one particular anesthetic.

During the past three and one-half years we have used avertin anesthesia in the Atlantic City Hospital for 736 cases. What I have to say is based upon our experience with that series and is supplemented by a review of numerous reports dealing particularly with its use in your specialty. Our confidence in its anesthetic properties have increased each year, so that more than half of our cases were recorded in the past year. In this series of cases there has not been a death that could be unquestionably ascribed to the immediate effects of avertin.

The use of avertin in the surgery of your particular specialty presents no problems that are not encountered in general surgery, except for those types of cases in which the preservation of pharyngeal and laryngeal reflexes is an all important consideration. Therefore a general discussion of avertin will be first presented, and then its application to eye, ear, nose, throat and laryngeal work will be discussed.

Avertin when given by rectum causes sleep to come on rapidly, smoothly and quietly; and unconsciousness occurs within a very few minutes and the maximum depth is reached in about 20 minutes. This effect is produced

because 50 per cent of the avertin is absorbed within 10 minutes, and 75 per cent within 20 minutes. Thereafter the absorption is much slower and keeps up the anesthesia stage.

During anesthesia the pulse rate becomes moderately increased, the blood pressure drops 10-20 mm. Hg., and the respirations become slower and the excursions shallower. Cyanosis has not occurred in our series, and pallor has been rare. These three delicate mechanisms are effected by all forms of general anesthesia.

Anesthesia is only partial in about 90 per cent of cases, and requires the addition of a supplementary anesthetic. We never aim to secure total anesthesia; our aim is only to establish basal anesthesia. We are sure that therein lies the safety of the method.

The recovery period is rarely more than four hours, and the reaction is usually smooth. Occasionally a patient becomes irrational, and a little later may become unmanageable. We have found that the use of a hypodermic of morphia gr. 1-6 to $\frac{1}{4}$, will prevent this if given with the first signs of restlessness. Children are more apt to have a noisy recovery period than are adults.

POST-OPERATIVE COMPLICATIONS

(1) Strangulation is the one serious accident which may happen. Avertin causes an early and prolonged relaxation of the masseter muscles and the tongue, and as a consequence, a dropping of the lower jaw which favors "swallowing the tongue". This is prevented by having an attendant constantly present to keep the head turned to one side and to pull the tongue forward immediately should such an accident occur.

(2) Vomiting is much less than from ether and is never persistent.

(3) Urinary retention occurs with about the same frequency as with ether, and in both cases is more dependent upon the type of operation than upon the anesthetic.

(4) Bronchitis and pneumonia occur with

far less frequency than occurs following ether anesthesia, and compares equally with nitrous oxide.

(5) Our studies show that post-operative changes in blood chemistry and phenolphthalein elimination are so slight as to be unimportant.

INDICATIONS

Broadly speaking avertin can be used for the entire domain of surgery. Any anatomical region can be attacked under this form of anesthesia. There are, however, no absolute indications. There are no physiological indications such as exist, for instance, for spinal anesthesia.

Avertin seems especially useful for the following:

(1) Highly nervous and overwrought patients.

(2) Those who have previously suffered much from other forms of anesthesia, and for those who dread an anesthetic.

(3) For surgery about the head, face, or neck, so that the anesthetic apparatus can be out of the way.

(4) For operations on tuberculous subjects that cannot be performed under local anesthesia.

In our opinion these are the only real indications for its use. We frequently use nitrous oxide or ether when there is no particular indication except that a general anesthetic is required; and the same is true of avertin. An expression on the part of a patient is frequently the deciding factor.

CONTRAINDICATIONS

As with all other types of anesthesia it is more important to know when *not* to give a particular type than when to give it. The following we consider absolute contraindications:

(1) Kidney disease, whether in the form of nephritis, infection, calculi, cysts, or tumors. Nephritis, which is more than minimal, should contraindicate its use. Renal infection of advanced degree which gives poor dye tests; bilateral renal or ureteral calculi or tumors of either kidney contraindicate its use. Avertin is not a specific kidney poison.

(2) Liver conditions, when there is reason to believe that the liver function is def-

initely impaired, as occurs in cases of obstructive jaundice, carcinoma of gall-bladder, liver or pancreas, cirrhosis of liver and peritoneal ascites. Avertin is not a specific liver poison.

(3) Acute respiratory disease or chronic pulmonary disease, when the ventilating surface is markedly reduced.

(4) Debilitated states, dehydration, and shock contraindicate avertin.

(5) Diabetic patients should not be given avertin, not because, as some believe, that the blood sugar is increased by avertin, but because the anesthesia lasts too long, which allows starvation acidosis to develop.

(6) Cases requiring tracheotomy should not be given avertin, because the cough reflex is subdued.

APPLICATION TO EYE, EAR, NOSE AND THROAT OPERATIONS

If the statements which I have already made are accepted, then the discussion as regards your specialty can be very materially simplified, and approached with less timidity and apology for our apparent lack of application to this particular field in our series. We have only used avertin for 10 cases of tonsillectomy. This was on Dr. Sinkinson's service. The general statements already made apply equally to operations on the eyes, whether of the lids, intra or extra ocular, or orbital; to operation on the mastoid, including brain abscesses of otitic origin; to operations on the frontal and maxillary sinuses; to extra nasal operations, and bronchoscopic and esophagosopic work; as well as to operations on the chest, abdomen or extremities. This leaves for discussion pro and con its application only to those operations which may give rise to hemorrhage in the oropharynx and for operations on the larynx.

In my opinion these are the only class of cases upon which there could be disagreement as to danger factors in its applicability to your field.

Avertin in full dosage, sufficient to produce a complete and unsupplemented anesthesia, causes a paralysis of the gag-reflex, as the pharynx and larynx become as surely anesthetized as does the rest of the body. This, of course, all of us recognize as most dangerous in the class of cases under discussion, which

includes first of all tonsillectomy and adenoidectomy, also turbinectomies, septum operations, and operations upon the ethmoids and sphenoid cells, because all of these may give rise to bleeding which might find its way into the oro-pharynx and from there into the lungs; and secondly major laryngological operations—laryngofissure, laryngotomy, laryngectomy, etc.

If it is possible to so regulate the dosage of avertin so as to avoid deep narcosis and thereby avoid anesthesia of the pharynx and larynx, and paralysis of the gag-reflex, one could safely use avertin for those operations of the first class. Those of us who use avertin frequently know that it is possible, by reducing the dosage, to lessen the depth of anesthesia. In general surgery we use 90 to 100 mg. of avertin per kilo of body weight. If we reduce this dosage to 70 and 80 mg. per kilo of body weight, we will obtain the desired degree of narcosis. This degree of anesthesia however, is not satisfactory for the performance of the desired surgery, so it becomes necessary to administer an additional anesthetic. Local anesthesia, which works so admirably in conjunction with avertin in other anatomical regions, does not answer here, because the patient is liable to twist his head about, so it becomes requisite that nitrous oxide and oxygen or ether be given in addition. This manner of handling this particular field of surgical endeavor is satisfactory and successful, and the reflexes are not abolished. Many operators have reported their experiences with satisfaction for tonsil and adenoid operations. For certain types of patients it is a method to be recommended.

The second class of cases (major laryngeal operations) the reaction from the anesthetic is slower and more tranquil than from gas and ether, and their success so frequently depends upon the early return of the cough reflex to rid the trachea or larynx of mucus, that avertin would not seem the best selection. The selection of cases should follow the same lines that we use for general surgery.

There is one more point and that has to deal with the use of avertin for children. As with all general anesthetics children are particularly good risks and the scale of dosage is

exactly the same as for adults. We have given the regular size dose to many children, the youngest being only two and one-half weeks old; and incidentally, this was given to allow the performance of an oral operation.

The mastoid, the orbital contents, the exterior of the nose, and the frontal and maxillary sinuses seem to be locations which are particularly suitable for this form of anesthesia, because of elimination of the necessary anesthesia apparatus and the anesthetists hands. By the use of nasal catheters the supplementary anesthetic is delivered advantageously. Of course, I am here referring to operations that cannot be easily performed under local anesthesia. For intranasal and throat operations it is a satisfactory anesthetic, and is especially valuable in those of neurotic make-up.

For those eye operations that are generally done with greater facility under general anesthesia (eneucleations, glaucoma, post-operative expulsive hemorrhage, lid operations, extirpation of lachrymal sacs), avertin should work admirably, because the eye is quiet and motionless, the pupil is contracted moderately, intra-ocular tension is reduced, extra-ocular muscles are relaxed, the conjunctiva is pale, and there is profound corneal anesthesia.

For those operations requiring the use of a cautery, avertin is safe because it is not eliminated through the respiratory tract.

I have not stressed the advantage of avertin to the psyche of the patient, because all of you are informed on this point. We are particularly impressed with the fact that the patient is calmly put to sleep in his own bed, moved to the operating room, operated upon, and returned to his bed without his knowledge.

I am not advocating that you give up the use of ether and gas, or local anesthesia, and substitute avertin. I think that it would be a mistake for you to do so. What I am advocating is that you may rely upon it when the indications for its use appear.

Our experience with avertin has been most gratifying. We consider it the most humane anesthetic yet devised, and we feel that there is justification for the inclusion of avertin amongst the list of recognized anesthetic agents.

PRE-SCHOOL MEDICAL EXAMINATIONS IN HACKENSACK

By J. WILLIS DEMAREST, M.D., Hackensack, N. J.

A large number of physical examinations of children of pre-school age were made in Hackensack, New Jersey, during the Spring of 1933, through the coöperation of the school physicians and nurses, and the Parent-Teacher Association. The procedure was that which was recommended by the Committee on School Physicians of the Medical Society of Bergen County, in which Hackensack is located.

Two dates for the registration of new pupils were set for each school during the first week in May. By letters home with pupils, by personal calls of nurses and P.-T. A. workers and by newspaper stories, these dates were published. A total of 227 new pupils was registered. A committee member was in constant attendance during registration to explain the purpose and urge attendance at the examination two weeks later. A total of 171 was examined, proving the worth of this contact.

One afternoon was given to each school for the actual examinations. The doctor, two nurses and enough P.-T. A. members to assist with the clerical work and the children's play were present. Each child had to be present with a parent or an adult of the household. In only four instances did an older brother or sister accompany the child. Each child was stripped and given a loose cotton examining garment. The work was done in kindergarten rooms where toys, and boxes, were available to keep the children busy. In only a few instances was a child so refractory as to make the examination difficult.

The regulation form adopted by the National Parent-Teacher Congress was used. The information required included the age of talking and walking, excretory habits, habits of sleep, diet and behavior, and a record of past or recent illnesses. It did not, but should have included room for the social and economic status of the home.

Realizing that clinics, free protection against infectious disease, and charity procedures in school medical work are on trial, the parent of each child was personally asked by the doctor or nurse the name of the family physician, and was urged to visit him when defects were found. In some instances the nurse called the doctor to inform him of needed immediate attention.

PRE-SCHOOL EXAMINATIONS

School No.	1	2	3	4	5	6	7	Totals
No. Registering ..	41	33	16	53	13	41	30	227
Total No. examined	32	34	13	30	13	29	20	171
Bad teeth	11	13	3	9	4	8	2	50
Infected tonsils ..	19	5	5	15	3	17	4	68
Not vaccinated ..	30	30	9	20	10	22	7	128
Not immunized ..	29	28	9	14	7	19	8	114
Need circumcision	3	1	0	3	1	4	0	12
Poor posture	0	0	0	1	0	1	0	2
Skin disease	1	0	0	0	0	0	0	1
Ear disease	1	3	0	0	0	1	0	5
Heart abnormal ..	0	0	1	0	0	0	0	1
Nervous	0	0	1	0	0	0	0	1
Poor nutrition ..	4	6	0	0	0	2	1	13
2 Stars								
Blue Ribbon ...	0	0	2	3	0	1	12	18
1 Star								
Blue Ribbon ..	2	3	2	7	1	3	7	25
Blue Bibbon ...	7	13	7	6	3	2	4	42

(Blue ribbons—no defects. With one star if either vaccination or immunization has been done. With two stars if both vaccination or immunization have been done. These awards were given out at special assemblies in October.)

School No. 1—Almost entirely Italian population.

School No. 2—Middle class section, many Irish.

School No. 3—Better class section.

School No. 4—Best Residential section.

School No. 5—Exclusively Negro registration.

School No. 6—Many Italian, Polish, Negro families.

School No. 7—Good residential section, fair proportion of Jewish population in this neighborhood.

The Hackensack Board of Health has a Fall campaign for diphtheria immunization and a Spring vaccination program. The work always has been done in the school buildings, the school physician usually being in the Board's employ. This is usurping the work of the private physician, and again the parents were urged to go to him for this protection.

It is felt that the program has so far resulted in:

(1) Closer contact between the parent and the nurses and doctors in the school health department.

(2) Emphasizing the office of the family physician.

(3) Better understanding of the work done by the P.-T. A.

(4) Discovery of many defects which would retard the children in their start in school.

The committee members of the P.-T. A. have promised that the parents of each pre-school child again will be visited during the summer, so that a check can be made on the correction of defects. Another check will be made by the physicians and nurses as soon as school begins in the Autumn.

A large proportion of parents will send their children to kindergarten in good physical condition. It is to the thoughtless and the indigent parent that the efforts must be directed. The success of the plan depends mainly on the work of the P.-T. A. members. Their cooperation has been of the highest type.

DISCUSSION

Dr. C. R. Brown, Arlington: These figures are very interesting. I don't think it is debatable as to the necessity of this which the doctor has demonstrated; but the very fact that 90% of the children were unable to get in the blue ribbon and two-star group indicates that the family physicians in general in the locality has fallen down. If it were not true, they would have sold to them vaccination and immunization against diphtheria before they got to the school age, and no physician has any ground for criticism of public health work who can't get up and say, "When my babies reach six months or twelve months (if he wishes to put it at that, or any certain age), then I put it up to the parents: do you want him immunized against diphtheria, and try to explain to them, taking a few minutes of their time to explain it", and also at somewhat the same period or later, if he sees fit to get them vaccinated.

A large percentage will come across, at least on the first, and usually on the second also, if it is so presented to them.

If they don't come to you, they will go into some of the clinics to have it done.

Dr. Joseph Schapiro, Union City: A pre-school child may be classed anywhere within the age-limits of from one to five years. However, all such pre-school children should be examined by the family physician, who would be in a much better posi-

tion to advise the parents than the school physician. The family doctor knows the economic status, mental attitudes, reactions, etc. The school doctor lacks this necessary information. Indigent cases should be referred to hospital clinics for such examination. Pre-school examination of children has been recognized for many years as a vital public health measure, but at the present time the tendency everywhere is to have this work done by the family doctor and not by the school physician.

F. Edward Whitehead, Hackensack: Two years ago I was appointed as Executive Secretary of the Medical Society of Bergen County. At that time this subject was before the Society and it has been brought more or less to a head. It is the belief of the Society that the doctors need probably as much education as the other members of the community. They felt that possibly this physical examination should come under the family physician. They are asking the question how to control it and do it efficiently. They have set aside that for the present because of the fact that they have no absolute solution to it, but insofar as the immunization and vaccination against smallpox are concerned, they have taken and asked resolutions for that program.

The Public Health Nursing Committee, the School Physicians Committee, and the Public Relations Committee, in joint session, determined upon a set of recommendations as follows:

"(1) That a continuous educational campaign be carried out among our own doctors through:

"(a) Demonstrations of the technic of administering diphtheria toxoid or toxin-antitoxin, and of giving and reading the Schick Test;

"(b) Cards to doctors informing them of the newer thoughts in regard to diphtheria immunization; and

"(c) By the periodic examination and publication of information in our Bulletin.

"(2) That an effort be made to have our doctors immunize the babies before the end of the first year.

"(3) That no reliance be placed upon a public campaign for immunization against diphtheria.

"(4) That our Society adopt a standard form of notification which shall bear the seal of the Society."

These have not been printed as yet as there has not been time, but they will be. On the top of the first one it says: "Diphtheria can be prevented." We have our County seal, which gets across the idea that it is a County Medical Society program.

Mr. Whitehead then showed copies of the following forms to be used by family doctors in their efforts to secure the cooperation of permits in bringing the children to be immunized:

(1) Invitation to bring the child to the doctor for immunization.

(2) A similar note to have the Schick test made.

(3) A form of certificate of immunization.

These forms are prepared and supplied by the Bergen County Medical Society.

CARDIOVASCULAR SYPHILIS

Analysis of 1730 Autopsies

SOLOMON WEINTRAUB, M.D., New York City

For this presentation, an analysis was made of 1730 autopsies performed at Harlem Hospital from September 1, 1925, to September 1, 1932. During this 7-year period many types of syphilitic cardiovascular lesions have been found at postmortem. We will discuss these lesions, which for purpose of description will be taken up in this order, namely: myocardium, endocardium, coronary arteries, valves, aorta and its branches.

TABLE I

ANALYSIS OF 1730 AUTOPSIES

September 1, 1925, to September 1, 1932

HARLEM HOSPITAL

Positive cardiovascular luetic lesions	2.9%
Death due to cardiovascular lues	2.0%
Aneurysms	1.3%

The myocardium in our cases showed grossly: hypertrophy, dilatation, fibrosis and atrophy. The left ventricle appeared most commonly to be the seat of involvement, more especially at the apex. We have had 2 cases

TABLE II

ANALYSIS OF KAHN TESTS

From June 16, 1926, to September 24, 1932

HARLEM HOSPITAL

Result	Blood No. of Cases	Percent- age	Result	Spinal No. of Cases	Percent- age
Neg.	12928	68.13%	Neg	1008	88.0%
4+	3085	16.3%	4+	11	0.96%
3+	1118	5.89%	3+	25	2.18%
2+	799	4.21%	2+	34	2.97%
1+	568	2.99%	1+	28	2.45%
Doubtful	496	2.61%	Doubtful	39	3.41%
Total	18974		Total	1145	

of marked thinning and aneurysmal dilatation of the left ventricle. One of these cases, which clinically exhibited all the classic objective and suggestive signs of ruptured gastric ulcer, at necropsy showed a ruptured left ventricle with a hemopericardium. In this group of myocardial lesions there were a great number of cases which were admitted to the hospital in

varying degrees of cardiac decompensation and which subsequently reached the autopsy table. Microscopically, the muscle fibers were separated and distorted by infiltration of lymphocytes and plasm cells.

TABLE III

ANALYSIS OF 50 CASES OF CARDIOVASCULAR SYPHILIS
HARLEM HOSPITAL

RACE	SEX
White	Male
Colored	Female
10%	76%
90%	24%

AGES	SYMPTOMS
20-30 years	Dyspnea
30-40 "	Cough
40-50 "	Edema
50-60 "	Precordial pain
Over 60 "	Palpitation
6%	Abdominal distress
22%	Hemoptysis
36%	Coma
26%	72%
10%	40%
	32%
	30%
	24%
	18%
	12%
	8%

The endocardium failed to show any lesion in either the mural portion or that covering the mitral valve. This important part of the heart appeared immune to attack by the spirocheta pallida.

TABLE IV

ANALYSIS OF 50 AUTOPSIES OF CARDIOVASCULAR SYPHILIS
HARLEM HOSPITAL

History of chancre	36%
Earliest chancre at 13 years of age.	
Earliest lesion at 7 years after 1° infection.	
Oldest lesion at 30 years after 1° infection.	
Earliest aneurysm at 30 years of age.	

The coronary arteries rarely showed extensive involvement. This observation agrees with the findings of others. In some of our cases we found lesions extending for about 2 to 3 cm. from the mouth of the vessel. The distal portions of the vessels were smooth and apparently free from gross pathology. Even in patients well past the fifth decade this was found to be true. The ostia of the coronary vessels were partly closed and sometimes it was difficult to pass a probe even minute in caliber into the lumen. One case in the series

From the Department of Pathology, Harlem Hospital, New York, N. Y. Read at the Annual Meeting of the Medical Society of New Jersey, Atlantic City, June, 1933.

studied; presented an aneurysm which involved the coronary artery.

The *valvular* lesions appeared to be confined to the aortic valve. Here we found, grossly, various degrees of thickening of the cusps' edges, shortening of the cusps, and a marked widening of the spaces among the cusps. These lesions produced the clinical manifestations of insufficiency.

TABLE V

ASSOCIATED CONDITIONS FOUND AT AUTOPSY IN CASES
OF CARDIOVASCULAR SYPHILIS
HARLEM HOSPITAL

Associated Conditions	No. of Cases
Cardiac decompensation (myocardial failure)	16
Lobar pneumonia	4
Pulmonary tuberculosis	1
Peptic ulcer	1
Cerebral hemorrhage	1
Bacterial endocarditis	2
Arteriosclerosis	5
Atelectasis of lung	4
Pneumococcus meningitis	1
Luetic cirrhosis	4

All the lesions thus far described were found to be usually associated with *luetic aortitis*. Grossly, the aorta showed at its origin

from the left ventricle, innumerable fine longitudinal striations—sometimes so fine as to be almost imperceptible to the naked eye. The elasticity of the wall was impaired. The width of the vessel at its ascending portion was found to be dilated. Microscopically, these lesions showed a marked infiltration of lymphocytes and plasma cells around the vasa-vasorum of the adventitia. These perivascular infiltrations were also seen, to a lesser extent in the media. The nutrition of the media was interfered with by partial obliteration of these minute vessels. This resulted in a destruction of the elastic fibers of the media with resultant thinning. The intima showed some necrosis and fibrous tissue replacement. We were, therefore, dealing with an anemic infarction of the media and intima, produced by an obliterative endarteritis of the vasa-vasorum of the adventitia. As the vessel became progressively thinner it led to the lesion so commonly seen at Harlem Hospital—aneurysm. This latter was really the end-result of the destruction of the media combined with the constant pounding of the blood against a weakened wall.

MEDICO-LEGAL ASPECTS OF MALPRACTICE

By MAX KUMMEL, M.D., Newark, N. J.

When the state grants a doctor license to practice medicine and surgery, it not only confers upon him the rights and privileges for his own benefit, but imposes moral obligations and legal duties for the protection of his patients. A violation of a moral obligation is referable to the ethics committee and acted upon by the State Board of Medical Examiners; a violation of a legal duty is actionable at law and constitutes the basis for a malpractice suit.

RIGHTS OF A PHYSICIAN

A physician is not liable for malpractice arising from his exercise of the following rights:

(1) He may refuse arbitrarily to respond to a call even if there are no other doctors available.

(2) He is not bound to render professional service to anyone who applies for it.

(3) He may withdraw from any case upon reasonable notice.

(4) He has the right to demand legal payment irrespective of outcome.

(5) He has the right to practice that system of medicine which he holds himself out to follow.

OBLIGATIONS

A physician is subject to the following obligations:

(1) To possess a reasonable degree of skill and learning.

(2) To exercise a reasonable degree of skill and care in the practice of his profession.

(3) To keep abreast of the times generally.

(4) To follow accepted methods of treatment—deviates at his peril.

(5) To leave detailed instructions and orders for the care of his patient.

(6) To continue in attendance until discharged, terminated or withdrawn.

(7) To advise calling a consultant in difficult cases and use reasonable care in selecting one.

A violation of any of the above duties resulting in injury to the patient may constitute negligence and be actionable at law.

The negligence of a physician or surgeon cannot be inferred from a bad result. The doctrine of *res ipsa loquitur* (the thing speaks for itself) should not apply to malpractice cases, because a physician is not an insurer and his contract does not imply a perfect result or even a recovery. The burden of proof rests with the accuser, and whether or not negligence existed is a question for the jury to decide. To sustain the charge of malpractice there must be a preponderance of evidence from expert witnesses to show lack of skill and judgment in the diagnosis and treatment. *Ely vs. Wilbur*, 10 Atl. 358; *Lolli vs. Gray*, 128 Atl. 256; *Grimaldi vs. Zeglio*, 33 Atl. 475.

DIAGNOSIS

A patient is entitled to an ordinarily careful examination, such as circumstances and the condition of the patient will permit. A physician or surgeon is required to use reasonable skill and care in determining the condition of the patient and the nature of his ailment; and is liable for a failure, due to a want of the requisite skill or care, to diagnose correctly the nature of the ailment, with resulting injury or detriment to the patient. On the other hand, a physician or surgeon is not responsible for a mistake in diagnosis if he uses the proper degree of skill and care. Furthermore, it has been held that unless improper treatment follows, a wrong diagnosis gives no right of action.

In *Mortimer vs. Dr. K*—, 130 Atl. 547, J. states: "As to the matter of diagnosis—if you

find that the defendant in this case did not use reasonable skill and diligence in diagnosing the plaintiff's ailment, and that this error in diagnosing led him to perform an operation which was improper under the circumstances, and that this operation resulted in an injury which brought on a gangrenous condition in the leg, necessitating the amputation of the lower portion, your verdict should be for the plaintiff."

ERRORS OF JUDGMENT

A physician or surgeon is not liable for an honest error of judgment provided there is a reasonable doubt as to the nature of the condition involved or as to the proper course to be followed or where good judgments may differ. This does not apply if the errors occur by reason of the physician's lack of knowledge which he should possess, or his failure to exercise proper care. A distinction should be made between error and negligence in judgment. In operating on an emergency, a surgeon is not liable for an honest error of judgment.

CONSENT

A physician is liable for operating upon a patient unless he obtains the consent of either the patient or his legally authorized representative. A surgeon who performs an operation without his patient's consent, express or implied, commits an assault for which he is liable in damages. *Brennan vs. Dr. P*—, 83 Atl. 948. Consent may be implied from circumstances and an operation without consent may be demanded by an emergency. (*McGuire vs. Rix*, 225 N. W. 120.) If in the course of an operation to which the patient consented, the physician discovers conditions not anticipated before the operation was commenced, and which, if not removed, would endanger the life of the patient, he will, although no express consent be attained or given, be justified in extending the operation to remove and overcome them. However, the removal of a bone during operation renders the surgeon liable to damages. The principle upon which this is based is that "The patient must be the final arbiter as to whether he shall take his chances with the operation or take his chances of liv-

ing without it. Such is the natural right of the individual which the law recognizes as a legal right."

MISTAKE IN PRESCRIPTION

Where the injury or death of the patient results from the negligence of the doctor in writing a wrong prescription, he is liable, even though the druggist who compounds the prescription is also guilty of negligence. However, a physician is not liable for a druggist's negligence in compounding a prescription properly written by the physician.

MISINFORMING PATIENTS

A mere expression of an opinion that a cure can be effected is not fraud. However, if the doctor wilfully represents that he can bring about a cure, knows it to be untrue and the patient relying on his statement accepts treatment and is not cured, the physician is liable for an action for deceit.

LIABILITY FOR ASSOCIATES

Partners in the practice of medicine are all liable for an injury to a patient resulting from the lack of skill or negligence of any one of the partners. A doctor is liable for the negligence of his assistants provided they are in his employ or he exercises control over them. A physician is not liable for the negligence of hospital nurses, attendants or internes, who are not his employees, if he has no knowledge thereof or has no connection therewith, or if it is not discoverable by him in the exercise of ordinary care, or unless he is negligent in permitting them to attend the patient. A physician who merely administers an anesthetic to a patient operated upon is not liable for the negligence of the operating surgeon. A physician or surgeon is not liable for the negligence of a substitute unless the latter is in his employ, is a partner or agent or unless due care is not exercised in the selection of the substitute. In the case of *Holborn vs. Meyers* 58 N. J. L. 193; 33 Atl. 359, the court held that Dr. P. being engaged in a distinct and independent enterprise of his own was not the servant or agent of Dr. M. in this matter, and

that, therefore, Dr. M. was not liable for his unskillful or negligent acts.

CONTRIBUTORY NEGLIGENCE

If in an action for malpractice, it can be proven that the negligence of the patient or those acting for him, proximately contributed to the injury complained of, there can be no recovery in the courts of New Jersey. The doctrine of comparative negligence does not apply in our state. By this is meant that if the patient fails to follow instructions, refuses to permit proper treatment, fails to return for treatment or neglects to procure needed assistance when advised by his physician, he is guilty of contributory negligence. However, if the patient by an independent act of negligence increases or augments the injury caused by the malpractice, it does not prevent a recovery but goes in mitigation of damages.

STATUTE OF LIMITATIONS

This is the period of time so limited by law for the bringing of actions. In New Jersey a suit for damages based on malpractice is outlawed after two years from the last date of professional attendance, while a suit on implied contract for services rendered is not outlawed for six years. Therefore, if you come across a disgruntled patient with a poor result, do not send a bill or insist too strongly on payment before the two years are up. May I warn you that the same patient, upon proper advice, might return for just one additional treatment after the two years and reestablish his status. If you start a suit to collect within two years, you may get a counterclaim for damages in response; while if you sue after two years you may get a counterclaim for breach of contract, which is neither encouraging to the attorney nor profitable to the client.

SOURCES OF MALPRACTICE SUITS

Injuries to bone constitute the most prolific source of malpractice litigation. It has been stated by Lockwood that "Bones are supposed to be filled with red and yellow marrow; in reality they are full of black ingratitude." Very frequently a fracture involves not only dam-

age to the bone but to the reputation of the unhappy doctor. However, the majority of these cases are avoidable because they are based on the omission or lack of proper x-rays. Out of a series of 50 English cases based on fractures, 56% (28) missed the fractures, 12% (6) overlooked a malunion and 18% (9) missed bone or joint complications.

Next in order of frequency is the alleged malpractice in connection with x-ray and electric treatments. However, no practitioner of medicine or surgery is exempt from it. The surgeon has been sued for a wrong diagnosis, improper, premature or delayed operation, using wrong instruments, and leaving foreign bodies in abdomen. The obstetrician's grief came from absence at birth, lacerated perineum, gauze left in vagina or placenta in uterus, child traumatized during delivery or its eyes injured immediately thereafter. The eye man has been charged with overlooking a foreign body and failing to remove it while a mastoiditis resulting from a prolonged nasal packing was credited to the rhinologist. The neurologist has been held to account for conspiracy and unlawful restraint of liberty of the mentally deranged. The general practitioner has been the proverbial scapegoat not only in actions involving alleged malpractice on his part but has been joined as a party defendant in litigation involving consultants and independent practitioners.

MALPRACTICE INSURANCE

I believe that it is essential for every doctor to carry good insurance even if the rate is higher, because "Good insurance is never cheap, and cheap insurance is never good." However, even the best insurance does not protect you; it merely defends you and indemnifies your losses. Hence, it is the duty of every physician to exercise utmost care and take all possible precautions to guard against and discourage such lawsuits as if no malpractice insurance existed. Furthermore, in these days of economic stress and strain you never know who is left holding the bag. The carrier may not be in business or may refuse to defend on grounds just or unjust. An instance

of this kind occurred lately, whereby the doctor, who had paid for his policy and who could ill afford it, is obliged to defend a suit at his own expense. By an arrangement with the county medical society, the insurance company issues a group policy to members in "good standing". Owing to the depression, the doctor did not pay his dues on time and thus automatically excluded himself from the good standing class. A malpractice suit arose during the critical period and, when notified, the company refused to defend the case in spite of the fact that it has accepted payment and never sent notice of cancellation or refund of premium.

You cannot stop anyone from suing you, but you can make it undesirable and extremely discouraging by observing the following commandments:

- (1) Obtain a detailed and accurate history in your own handwriting.
- (2) Keep complete records of the physical findings and special treatments.
- (3) Follow accepted methods of treatment. Do not experiment with your patients.
- (4) Give proper and detailed instructions for the care of your patient.
- (5) Do not abandon a patient without proper and sufficient notice.
- (6) When in doubt, demand consultations and be careful in their selection.
- (7) Demand an x-ray in every fracture even if it appears superfluous.
- (8) Obtain a written consent whenever the treatment involves a special risk, especially in radium, radiation therapy.
- (9) Do not give information concerning your patient to a third party.
- (10) Do not criticize your fellow practitioners directly or by implication—you do not know both sides of the story.
- (11) If you receive a letter from an attorney:
 - (a) Don't talk, turn it over to your attorney and let him do the talking for you.
 - (b) Do not discuss the case—the inquirer may be fishing for information.
 - (c) Do not disclose the insurance feature until the case is in suit.

THE TUBERCULIN TEST

By E. H. KLEINSCHMIDT, M.D., New York

Tissues which have once been sensitized by living tubercle bacilli develop the power to react to tuberculin. A positive tuberculin reaction means that tubercle bacilli have lived and grown in the body. Koch introduced the general or subcutaneous tuberculin reaction in 1890. In 1907 Pirquet developed a cutaneous scratch test, and in the same year Wolff-Eisner and Calmette described the conjunctival test, while Moro gave us the percutaneous or inunction test. About a year later Mantoux introduced the intracutaneous, and shortly after that Hamburger and Monti used the hypodermic or "Stich", method. Recently, Wolff introduced the patch test, which is applied by rubbing a semiliquid tuberculin ointment into the skin of the back, covering it immediately with a patch of adhesive. He claims that agreement between the patch test and the intracutaneous test in all dilutions as applied to 190 children was 95.8 per cent.*

More than 60 varieties of tuberculin have been employed at one time or another. Old Tuberculin is still most commonly used. The steps in the preparation of O. T. are: Growth of tubercle bacilli on a broth medium; sterilization of the culture by heating; filtration. The filtrate is O. T. and contains the soluble substances in the culture medium that have been formed by the growth of tubercle bacilli. The characteristic skin reaction is due to a tuberculo-protein, one of the metabolic products of the acid-fast bacilli.

The intracutaneous test is preferred by most workers because of its greater accuracy. For routine work with the intracutaneous test a dose of 0.01 mgm. of O. T. is generally used. If the test is negative it may be repeated with a higher dosage, namely, 0.1 mgm. The injection is made preferably on the flexor surface of the forearm after cleaning with alcohol, with a tuberculin syringe and a sharp 26 gauge needle. A needle or syringe that has been used

for tuberculin should never be used for the control nor for a Schick test, as tuberculin may remain active after boiling several hours and cause a reaction. The injection should be made intradermally, i. e., between the layers of the skin. A positive reaction is one that shows edema and redness at the end of 48 hours. If there is no edema, the reaction is regarded as negative. Reactions are arbitrarily graduated from one plus to four plus.

At no time since Koch discovered tuberculin has there been serious doubt as to what a positive reaction means biologically, namely, that the tissues are hypersensitive to tuberculin, which in turn means that the body has been invaded at one time or another by the tubercle bacillus. But how this should be interpreted in terms of diagnosis or prognosis has been the subject of tomes of debate, hinging on the basic question—do allergy and immunity parallel each other? Pinner pointed out that the interchangeability of the terms allergy and immunity leads to hopeless confusion. Allergy, he says, "means the altered reactivity of the organism following an infection. The term is an abstraction to indicate a known effect of a known cause. * * * Immunity is not defined by its causation but by the ultimate aim it is expected to accomplish. * * * Allergy is a causative term. Immunity is not a causative, but a teleological term."* Whether or not the allergic reaction in a given individual will serve to protect him is dependent on a number of unpredictable circumstances and accidents. A simile may help to show why it is fallacious to predicate immunity on allergy. The causation of a given rainfall can be scientifically determined with the aid of the barometer, thermometer, etc. But whether that particular rainfall would be desirable for crops or not would depend upon the season of the year, the stage of growth, the immediate occupation of the farmer and many other incidental circumstances. Pinner advocates eliminating from

From the National Tuberculosis Association, New York City. Read before the Section on School Physicians at the Annual Meeting of the Medical Society of New Jersey, June 8, 1933.

*A Tape Test with Tuberculin Ointment, Ernst Wolff—American Review of Tuberculosis, March, 1933.

*The Relation Between Allergy and Immunity in Tuberculosis, Max Pinner, American Review of Tuberculosis, February, 1931.

clinical usage the term immunity because of "its elusive nature whose doings are obscured by many extrinsic factors", which cannot be recognized or measured until the disease has run its course.

Stewart goes a step beyond that. Allergy, far from being a beneficial state, he believes, should be regarded as a detriment to the child. In a recent publication, he maintains that a primary infection does not afford adequate protection against consumption.* He sustains his opinion with evidence based on follow-up studies over a period of ten years, on 10,000 children in Lymanhurst School. Of the 84 children who developed reinfection or adult type tuberculosis, primary tuberculosis exclusively was found in 43 per cent on first examination; and in 29 per cent, primary and reinfection pulmonary tuberculosis coexisted when first examined. The balance, 28 per cent, yielded no pertinent information because of inadequate evidence.

These facts have a bearing on our conception of tuberculosis which, briefly, is as follows: The tubercle bacillus is in effect a foreign body—not an inanimate foreign body but one capable of reproducing itself. The physiological reaction against its invasion is essentially that of a mechanism to expel the foreign body, failing which there is a tendency to isolate it by the production of fibrous tissue. This first infection is a benign disease whose prognosis is good and which rarely causes death. But the first infection, whether a lesion is discoverable or not, sensitizes the tissues. Successful reinfection on sensitized tissue results in serious tuberculous disease of the destructive type commonly known as consumption. What is needed to become a consumptive is reinfection on tissues previously sensitized by a primary infection.

How does this conception affect our thought habits and our procedures? By accepting it, we are obliged to abandon the attempt to discriminate between infection and disease, assuming the infection to be determined by a positive tuberculin reaction without evidence of lesions, and disease by physical or x-ray signs. Tech-

nically speaking, tuberculous infection is tuberculous disease, for tissue sensitivity is brought about only as the result of some physical change engendered by the tubercle bacillus. The absence of x-ray markings does not rule out tubercle formation. With all its refinements, the x-ray is still a crude means of delineating shadows dependent on slight differences in texture or composition. It is less sensitive than post-mortem precision methods. Ghon's careful autopsy studies revealed primary tuberculous lesions in from 90 to 95 per cent of tuberculin positive children. Were our instruments delicate enough and our search thorough enough, we should probably be able to raise this percentage to 100. Every positive reactor, whether the lesion is in the lung or elsewhere, whether it is discoverable by x-ray or not, has primary tuberculosis.

This is not a mere academic distinction, but one of practical value for the reason that it recognizes sensitization as the important factor in the drama of the pathogenesis of tuberculosis. The degree of sensitization is probably of minor importance or at least of questionable value. Pinner asserts that higher or lower degrees of allergy do not give a measure of the degrees in the healing process. He advises the clinician not to try to correlate a strong tuberculin reaction either with high immunity or the reverse, namely, strong susceptibility. What is true of the healing process is not necessarily true of the protective mechanism, but there is no evidence to indicate that the degree of sensitization in a primary infection has any bearing on the body's ability to protect itself against reinfection. It is conceivable that a highly sensitized child, as evidenced by a four plus reaction, might overcome a reinvasion of tubercle bacilli more readily than if the reaction were only one plus. But it is equally plausible to assume that because of the higher sensitivity, reinfection might do greater damage. If our object is to prevent destructive tuberculosis (consumption) by anticipating it, it seems desirable and wise at this time to recognize every positive reactor as a possible candidate for consumption.

This attitude need not hinder us in our struggle to combat phthisiophobia. The use of the term "Childhood type of tuberculosis" has

*Does a Primary Tuberculosis Infection Afford Adequate Protection Against Consumption?—C. A. Stewart, Jour. of the Am. Med. Assn., April 8, 1933.

been of immense service in helping people to discriminate between a benign tuberculous condition and consumption, the killer. We may continue to use that label as well as the term "adult type tuberculosis", though for scientific use it might be better to substitute the equivalent terms "primary pulmonary tuberculosis" and "reinfection pulmonary tuberculosis".

A fair interpretation of the meaning of a positive tuberculin reaction is due every parent and teacher. We cannot properly say to them, as has often been said in the past, "a little tuberculosis is a good thing". Sensitization *may* serve to protect the child, but sensitization of itself cannot be depended upon to grant immunity. And certainly one cannot predict in any given case whether sensitization will serve to protect or to endanger. On the contrary, sensitivity must be regarded as a hazard, for it is only on sensitized tissues that the tubercle bacillus can produce consumption. A hazard, however, is no cause for alarm. It is a warning sign, which, if heeded, guides *away from danger*. The city dweller, for example, is constantly exposed to a traffic hazard. But knowing the risk (a lesson learned perhaps, by a minor accident) he need not fear the danger any more than if he passed his days in a peaceful countryside. We may say to parents (in simple words, of course) "a positive tuberculin test means that your child has at some time been attacked by the tubercle bacillus. No harm will come of that unless he is successfully reinfected. Therefore, keep watch over him and above all keep him away from people who have tuberculosis."

The application of the tuberculin test among groups of children is growing more widespread. The procedure usually has been, first, to test all children whose parents would consent, and second, to x-ray the reactors. In Massachusetts, where this plan was first worked out on an extensive scale, the findings among the first 200,000 children between the ages of five and fifteen were tabulated as follows:

- 28 per cent reacted to the tuberculin test and were x-rayed.
- 5 per cent (of the entire number) showed x-ray signs of childhood type of tuberculosis.

One case of adult type of tuberculosis was found in about every 3,200 children.

The general practice based on that plan and which prevails today is to dismiss from further consideration positive reactors who show no x-ray lesions. May we not question the soundness of this practice? If sensitization is so important a factor in the development of tuberculosis, why eliminate reactors in whom we have failed to find x-ray lesions of the childhood type which are acknowledged to be benign? And whether the reading is one plus or four plus should make little difference; both indicate a hazard. Not until we have satisfied ourselves that a reactor is not being exposed to an open case of tuberculosis should we withdraw our watchfulness over him.

Why then x-ray positive reactors? Stewart states frankly that he does so only for the special purpose of determining, if possible, whether reinfection types of tuberculosis are present or absent. To some this seems to be an extreme view, for it is argued that childhood type lesions vary in intensity, and therefore some children require more watchful care than others. At any rate, we may well heed Stewart's suggestion that "the roentgen study should not be accorded too much authority in determining that the individual has or has not primary tuberculosis, for that question is settled by the tuberculin reaction".

Ideally, every child should be tested periodically from the time of birth until he reacts for the first time. Every reactor should be under medical supervision at least until the "hazard" has been neutralized. But it will probably be long before the medical profession adopts the recommendation made years ago by Sir Robert Philip that the *fact* and the *date* of infection should be determined for every child. In the meantime we are exploring methods of testing as many children as possible, not only for the immediate benefit of those tested; but with an eye to the acceptance of the practice as a routine health measure, and with the hope that ultimately parents will assume the responsibility of having their children tested. Thus far, attempts to test groups of children have been made primarily through the school system. It has been uphill work but encouraging. Unfortunately, many parents object to "the

needle", and in group testing projects it is not unusual to find that only 50 per cent of the pupils may be tested. By careful advance preparation through educational means the prejudice against the test may to a large extent be overcome. The use of a test not requiring the hypodermic needle, such, for example, as Wolff's patch test, may help to solve the problem.

Is special permission to do the tuberculin test necessary? Recently the Attorney General of Ohio was asked that question. He ruled that "it would be legal for either a board of education or a board of health to give the tuberculin test to school children by means of the injection method or application of a salve if it is found to be a reasonable measure for the protection of the public health and safety". Considering that the tuberculin test determines sensitivity to the tubercle bacillus, which means that reinfection may result in serious tuberculous disease, and considering further that a tuberculin positive child is presumably exposed to an open case until the contrary is proved, it should not be difficult to prove that systematic testing in school children with tuberculin is a "reasonable measure for the protection of the public health and safety".

Has the time not arrived when the tuberculin test may be included as part of the regular inspection of the school child? The added time of the physician necessary to do this and the increased labor of nurses required for the follow-up is a small price to pay for the health protection values that would accrue from such practice. Tuberculosis is still the chief despoiler of youth. The strategic time to prevent tuberculosis is during primary and high school days.

The care of the tuberculous child is not the burden of this paper, but a brief summary may be tolerated. Manifest disease, of course, may require sanatorium care or its equivalent, but for first infection types generally, observation and good hygienic care is all that is needed. The summer camp provides a pleasant outing for infected children, but adds nothing of basic curative value. Admission to a preventorium unfortunately separates a child from home environment, and probably furnishes nothing that could not be obtainable outside a preventorium.

Lymanhurst, which is a day school planned for tuberculous children, seems to discharge its obligation fully without the aid of a sanatorium. Certified homes seem superior to resorting to institutional care. What is needed, in short, is good medical observation, intelligent home care, and school coöperation.

DISCUSSION

In answer to numerous questions, Dr. Kleinschmidt said:

The cost of the tuberculin test is negligible. The cost of the paper x-ray has been reduced to as low as fifty cents when used in large groups. Because it is speedy, it saves overhead expense. The chief item of expense is the follow-up of all positive reactors which the nurse is almost obligated to do.

As to parental consent, I don't think the time has come when we can waive it. The National Association has tried to help in the education of parents and teachers. We have published this leaflet called "The Tuberculin Test", which states in simple language what the test is and what it means.

In certain communities where careful preliminary education has been done, the ratio of consents rises as high as 85 or 90 per cent; whereas, in communities where no ploughing of the ground has been done in advance, we get only 40 per cent consents. The understanding of parents and teachers is essential in order to secure their consent. Most parents raise no objection to the x-raying of their children.

The portable x-ray is adequate for picturing the child's chest. There was a time when we thought that it wasn't delicate enough to bring out the small and indefinite markings, but it has now been developed to a point where it can be recommended for use. There is no need of the portable, however, in most of our communities, because we have access to sanatoriums or hospitals or private physicians with regular equipment. In rural districts, where it is difficult to get the children to the x-ray, the portable is of advantage.

Paper x-ray films now being experimented with are promising. Studies made at Bellevue-Yorkville indicate that they are just as reliable in interpreting the child's chest as are the transparent films, provided the roentgenologist accustoms himself to reading an opaque film, rather than a transparency. There is a great saving when the x-ray paper is used in conjunction with a machine developed for that purpose, whereby rolls of paper are used, with a capacity of about 300 exposures per roll. The machine is similar to a kodak, which enables the operator to pass quickly from child to child. The whole roll is developed at one time and then mounted on a frame. It is the time-saving element that greatly cuts down the cost. In a mass experiment done in New Haven they were able to do it at 50 cents a child.

A SUCCESSFUL OPERATIVE PROCEDURE FOR RESHAPING THE LOWER LIMBS

By GEORGE BLACKBURNE, M.D., Newark, N. J.

Miss A. B., a registered nurse, age 30, was admitted to St. Michael's Hospital, Newark, New Jersey, on April 7, 1930, requesting operation for reducing the size of the lower limbs, which were conspicuously large and unshapely. She has had abnormally large lower limbs as long as she can remember, the deformity being particularly marked between the knees and the ankles. In other words, she had ugly fat ankles.

After careful consideration and looking into the anatomy, it was decided to excise the fat by subcutaneous dissection in two stages, doing the outer side of each leg at the first sitting, and the inner side at a later date.

Plaster casts were made of the limbs and the following measurements were made before the first operation. See Table I.

First operation: Under gas-ether anesthesia an elliptical incision was made on the outer side of each leg from the upper third of the calf to the external malleolus, outlining a section of skin about two inches in width at its center and tapering at either end. The skin was undercut around this area to the midline anteriorly and posteriorly and to the upper part of calf superiorly, leaving about one-quarter of an inch of superficial fascia attached to the skin. The piece of skin and the entire remaining superficial fascia was dissected away from the deeper structures down to the muscle sheaths. Some attempt at beveling was made

at the edges of the resected fascia to avoid a ledge. The skin, with its thin layer of fascia, was now replaced and the skin sutured, using silk-worm gut sutures, one to the inch, and a continuous number one cat-gut stitch to complete the apposition. Snug dressings and bandages were applied. At the first operation I feared serum accumulation under the flap and inserted some small strips of rubber tissue. These were not used in the second operation and I consider them unnecessary. There was considerable shock, and apprehension on the part of the patient, which had to be combated with heat, morphine, adrenalin and hypodermoclysis. The first operation was done on April 8, 1930; the patient was out of bed in a chair on April 17, allowed to take a few steps April 19, and discharged April 28 with elastic bandages ap-

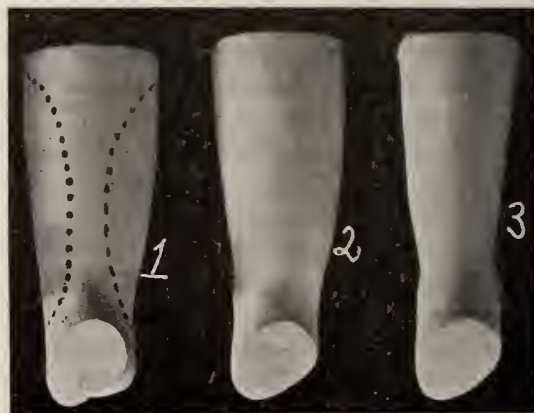


FIGURE 1.

1—Antero-posterior view of right leg before operation. (Dotted lines show areas of fascial resection.) 2—Antero-posterior view of right leg after first operation. (Note external malleolus showing.) 3—Antero-posterior view of right leg after second operation. (Note both malleoli showing.)

plied. There was a small amount of serous discharge from the rubber tissue drains and a small skin slough about one-quarter of an inch in width and one inch in length at the middle of the suture line on the right leg. Otherwise uneventful healing and limbs which from an anter posterior position particularly showed considerable improvement in contour.

TABLE I

THE MEASUREMENTS OF THE LEGS BEFORE THE FIRST OPERATION

Elevation above sole of foot in inches	Right leg circumference in in.	Left leg circumference in in.
4	11	10½
5	13¼	12
6	13¾	13
7	14¼	14¼
8	15½	15
9	16	15½
10	16½	16
11	16¾	16½
12	17	16½
13	17	16½
14	17	16¾
15	17	16¾

The patient was re-admitted March 15, 1932, for the second operation on the inner sides of the legs. Casts were again made and measurements recorded. (See Table II.)

TABLE II
MEASUREMENTS AFTER THE FIRST OPERATION

Elevation from sole of foot in inches	Right leg circumference in in.	Left leg circumference in in.
4	11	10 1/4
5	12	11
6	13	12
7	14	13 1/4
8	14 1/4	14
9	15	14 1/2
10	15 1/2	15 1/2
11	16	16
12	16 1/4	16
13	16 1/2	16 1/4
14	16 3/4	16
15	15 3/4	15 1/2

Operation March 16, 1932: The same operation was done on inner sides of the legs from the upper third of the calf to the internal malleolus, dissecting away an ellipse of skin and the entire superficial fascia. She was allowed out of bed on March 29 and discharged April 4 with uneventful healing. At this operation an extra pad of fat was also removed from the dorsum of each foot by subcutaneous dissection.

Following are the final measurements made on May 22, 1933:

TABLE III
MEASUREMENTS AFTER THE SECOND OPERATION

Elevation from sole of foot in inches	Right leg circumference in in.	Left leg circumference in in.
4	9 3/4	9 3/4
5	10 1/4	10 1/4
6	11	11
7	11 3/4	12
8	13 1/4	13 1/4
9	14 1/2	14 1/4
10	14 1/4	15
11	15 1/4	15 3/4
12	16	16
13	16 1/4	16 1/2
14	16	16
15	15 1/2	15 1/4

Observation May 22, 1933: Limbs fairly shapely, certainly not conspicuous by their size. Very symmetrical, except for a small depression in the scar just above the internal malleolus on the right side. The scars of the procedure do not show through ordinary silk stockings and she is greatly pleased with the result.

Moulds were made from the casts before operation and after the first and second proce-

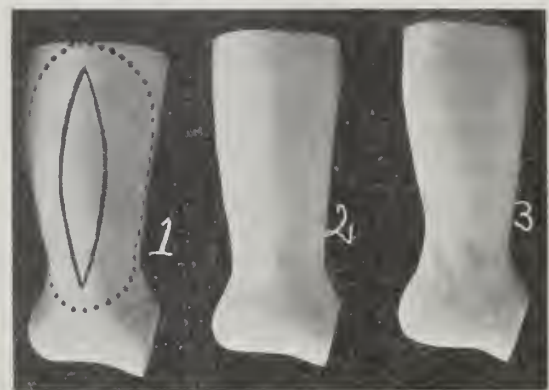


FIGURE 2.

1—Lateral view of right leg before operation. (Solid line shows skin incision; dotted lines shows area of fascial resection.) 2—Lateral view of right leg after first operation. 3—Lateral view of right leg after second operation.

dures. Photographs are shown of the moulds made from the casts of the right leg.

This operation is not entirely original, but is an adaptation of the Kondoleon procedure to both sides of the leg. Of course the superficial circulation is practically destroyed, there is exposure of a large area of tissue, and shock is severe. I would, therefore, not recommend the procedure upon any but young healthy adults in whom the size of the lower limbs is such as to give great embarrassment. It should be performed in two stages, doing the outer side of each limb first, and some months or years later doing the inner sides.

ROENTGEN CHANGES IN INTESTINAL OBSTRUCTION

By ROBERT P. STURR, M.D., Philadelphia, Pa.

The experience of recent years has emphasized the importance of an early diagnosis in intestinal obstruction, if surgical intervention is to be a life-saving measure. It is generally agreed that the one way of reducing the mortality rate is to shorten the time interval between the onset of symptoms and the establishing of a definite diagnosis.

Miller in a series of cases demonstrated that the death rate almost doubled between the 12 and 24-hour intervals. His total mortality was 60.9 per cent in 343 cases. Brill reported no deaths in which operation was done within 12 hours. Whereas, between the 12 and the 24, and the 24 to the 48-hour periods, his mortality rate increased approximately five times. Tuttle had no deaths when operation was performed in less than six hours after symptoms appeared, but showed a rise from 4 to 15 per cent when the time interval was between 12 and 24 hours.

The following communication is based on a study of forty cases of acute mechanical obstruction of the bowel diagnosed as such by x-rays and proven to be such at operation.

It is interesting to note that 70 per cent of these cases had rather acute symptoms for 48 hours before entering the hospital, and in many of the cases, the time interval was equally as long before x-ray studies were ordered.

If the roentgen examination is to be of much benefit in the acute cases, it is of the utmost importance that the examination be completed quickly and made at the earliest possible moment, with the minimum tax on the strength of the patient. In the study of the above series of cases, the plain roentgenogram has unquestionably been the most reliable and invaluable aid in the diagnosis of intestinal occlusion, and has been the chief determining factor leading to immediate operative intervention in cases clinically doubtful.

The value of x-ray examination in the diagnosis of intestinal obstruction was first pointed

out by Case in 1915. He demonstrated the value of the plain roentgenogram. Its diagnostic value is based on the following: (1) The gas content of the bowel and its distribution; (2) the arrangement of the distended loops of bowel; (3) the fluid content; (4) the recognition of the valvulae conniventes or Kerkring's folds in dilated parallel loops of small bowel.

Under normal conditions in adults practically no gas is present in the small bowel. The stomach and colon usually have some residual gas content. Collections of gas in the small bowel are therefore always significant, and usually the appearance and distribution of the gas enable the roentgenologist to determine the site of the obstruction. Carlson in 1931 demonstrated in dogs the definite evidence of gaseous distention in the bowel proximal to a simple obstruction as early as four to five hours, and after twenty-four hours the distention was general. The presence of fluid was demonstrated shortly after the five-hour period, averaging approximately eight to ten hours. X-ray examination was not found to be of the same diagnostic value in detecting the presence of strangulation as it was in the recognition of simple obstruction or occlusion of the intestines. In strangulated loops, gas was present in eight to ten hours, but the evidence of gaseous distention was inconstant.

In many cases of obstruction, gas is demonstrated by x-rays and appears long before clinical symptoms are apparent or pronounced.

The presence and location of fluid in the bowel has great diagnostic value. The fluid levels in the small bowel are centrally placed and have a short vertical height due to its general horizontal course and its numerous turnings. The large bowel shows fluid levels in the flanks and in the descending and ascending colon, which are practically vertical tubes suspended from the flexures. The vertical height of the gas column may reach four to six inches. Ochsner states that the finding of gas and fluid as evidenced by multiple fluid levels are so definite and pathognomonic that it is be-

lieved, when it can be demonstrated, it is of much more diagnostic importance than gas alone. With a ptosed transverse colon, gas and fluid may occupy the central field. The small bowel has a feathered or ribbed appearance due to its valvulae conniventes. Its edges give a serrated outline. These serrations are much more closely placed than the haustrations of the colon. The colon is characterized by blunter, deeper indentations due to its haustration. Case has described the appearance of the distended small bowel with its so apparent valvulae conniventes as herring-bone pattern. Also characteristic is the arrangement of these loops in parallel rows like the steps of a ladder.

METHOD OF EXAMINATION

If the patient's condition permits, he should be examined in the X-Ray Department. If not, exposures should be made at the bedside by means of the portable apparatus. Antero-posterior and lateral exposures should be made in supine and erect postures without exertion to the patient. In acute cases, this usually represents all the work that is required and a report can be returned within a few moments. The patient should have no enema or rectal irrigation before examination for two reasons. In the first place, the gas which may be present in the colon may be expelled and a wrong conception of the gas distribution obtained. In the second place, if the exposure is made too soon after the irrigation, retained fluid and gas introduced by it may not be completely absorbed or expelled and may give rise to small fluid levels in the colonic saccules.

In obscure or borderline cases, the barium enema may be required to eliminate colonic obstruction, but the use of the barium meal is seldom required and frequently the time consumed in such an examination would be fatal. Many authors strongly condemn the use of barium in any form in any case of suspected intestinal obstruction. Ginzberg states that in three of his cases acute obstruction was precipitated following an opaque meal. My experience has not confirmed the above. I have observed many of these cases at the time of operation whose intestinal tract was filled with barium, and saw no ill effects. I have also consulted numerous surgeons on this matter. Their

opinion is invariably that the presence of barium is in no way harmful as an obstructing factor or as an impediment at the time of operation.

In cases of acute obstruction, the surgeon finds the lumen of the small intestines distended with gas and fluid proximal to the point of obstruction and collapsed distal to this point. X-ray diagnosis is based on the same finding.

When there is organic alimentary obstruction, there will be dilatation and motor delay proximal to it, their degree determined by the type of obstruction and its site.

Carcinoma of the colon results in an immediate proximal dilatation and colonic motor delay, but it seems also that the dilatation is reflected proximally in a diminishing degree throughout the entire colon and is apparent in the form of the small intestine, giving distention as a result of recoil or relation stasis and may perhaps be reflected as far as the stomach. Gas and fluid accumulations take place. The stomach is the chief regulator of small intestinal motility. The rate of motility progressively decreases from the duodenum to the ileo cecal valve. Any organic process involving the small intestinal wall, either primary or secondary, will modify the x-ray shadow of the contents of the part involved and thus render direct diagnostic evidence of its presence. The character of the shadow of the distended intestine, its location on the film, and the extent of the distended loops are the diagnostic criteria, which, when correlated with the history of the physical findings, will determine the level of obstruction with a fair degree of accuracy in the majority of cases.

In partial obstruction, the picture changes, and more prolonged study and the use of bariumized solution orally and rectally are often indicated. The roentgenologist should always be on the alert to note the presence of duodenal or ileal stasis, frequently the forerunners of a complete obstruction. In every case of post-operative, post-appendiceal or post-salpingitic abdominal distress, one should suspect obstruction due to adhesions and careful roentgen studies made. It is a well known surgical axiom that the longer a patient lives

before operation, the shorter time will he live after operation.

In cases of strangulated hernia, the roentgenologist must always be on the alert for a lower obstruction, since frequently the hernia strangulates due to the vomiting caused by an obstruction lower down in the bowel. This was noted in two of our cases. The higher the obstruction, the more acute will be the symptoms. A very low obstruction may give no vomiting and give practically no early symptoms. Wagenstein and Lynch pointed out, the clinical signs of obstruction with the exception of pain as stated in the text books are really "ante mortem" signs coming on definitely only when the patient is, in the majority of cases, moribund. Watchful waiting in cases in which obstruction is suspected has in the interval of observation all too frequently lost valuable time during which the patient's resistance was gradually lowered and when the symptoms became definite he was already to be considered a poor surgical risk. We must be cautious and not too hasty in reporting our observations in post-operative ileus. The differentiation between a purely mechanical and a paralytic type of ileus is difficult when roentgen signs only are considered since they both give the same picture on the roentgen film in the majority

of cases. However, one suggestive sign is sometimes available when the paralytic ileus follows peritonitis. In this case, the walls between the dilated loops are sometimes seen to be thickened due to exudate over the surface of the intestines.

In peritonitis of lesser severity, gas may be demonstrated both in the colon and the small bowel. The presence of gas in the colon is an important factor in ruling out mechanical obstruction of the small bowel. In some types of post-operative distention, the peritonic process is mainly in the flanks and gas may be present in large amounts only in the large bowel.

It is of great importance from a practical standpoint to distinguish pre-operatively between colonic and small bowel obstruction. Ileal or jejunal obstruction is either actually or potentially strangulatory, and with few exceptions demands immediate surgical intervention. Obstruction of the colon, excepting for rare cases of sigmoid valvulus and in some types of intussusception, is obturating in nature and is usually neoplastic. These patients have usually been suffering from some degree of partial obstruction, but it is of utmost importance, from a surgical standpoint, that the exact site of the lesion or obstruction be demonstrated.

CONSTIPATION

CLINICAL AND ROENTGENOLOGICAL STUDIES OF ONE HUNDRED CASES

By SIGURD W. JOHNSEN, M.D., Passaic, N. J.

This study is based on 100 cases of constipation seen in private practice. All individuals with detectable organic disease were excluded.

The routine examination consisted of a complete history, physical examination, blood pressure and hemoglobin determination, urinalysis and roentgenological examination.

Statistical data shown in table I indicates that the ratio of males to females is three to one. The greatest number of cases occurred between the ages of thirty to thirty-nine years. The youngest patient was ten years old and

the oldest was seventy-eight years. The majority were married.

In table II are grouped the chief symptoms complained of in the order of frequency. The duration of constipation was hard to determine from the histories, varying from two years to fifty years. Various methods were used in controlling the constipation by the patients; the most frequent one being the use of laxatives. Most patients stated they had used all kinds of laxatives and alternated as one became ineffectual. Laxatives were taken daily by some, every other night by others, and three times weekly in other cases. A few were addicted to

high colonic irrigations and enemata entirely. Bran and roughage diets had been used by all, with no success.

Gas and belching was the most common complaint. Distress was extreme in some cases, but very troublesome in nearly all.

TABLE I
STATISTICAL DATA

Males, 25	Females, 75
Marital state—Single, 23; Youngest, 10 years	married, 70; widowed, 7 Oldest, 78 years
Ages—	
From 10 to 19 years	3
From 20 to 29 years	22
From 30 to 39 years	27
From 40 to 49 years	24
From 50 to 59 years	13
From 60 to 69 years	5
From 70 to 78 years	6

Pain occurred as the next most frequent complaint. Severe epigastric pain occurring after meals was present in fourteen cases. The history in these cases simulated ulcer. Fifteen patients complained of minor pain in the epigastrium, but marked heaviness and distress. In twenty-two cases the pain was abdominal and not localized to any particular spot. Eight cases complained of severe right-sided pain, localized to the lower right quadrant. These cases simulated appendiceal disease.

TABLE II
SYMPTOMS IN ORDER OF FREQUENCY

	Per Cent
Gas and belching	68
Pain (all kinds)	59
General malaise	39
Headache	18
Dizziness	14
Tympanites	11
Pyrosis	8

General malaise was complained of in thirty-nine cases. Some stated they were continually fatigued, others stated that they were easily fatigued. In all of these, the degree of malaise was so marked that they included it as a chief complaint.

Headache was not a major complaint in this series. Only eighteen were troubled with headache to a degree sufficient to make it a major symptom.

Dizziness occurred in fourteen patients; bloating in eleven, and heartburn in eight.

In some cases three or more of these complaints occurred in the same patient. The most

frequent combination was gas and belching, pain, and general malaise.

The symptomatology in many of these cases was that of organic disease. Complete examination, therefore, was necessary to rule out organic lesions.

In table III are noted the results of roentgenological examination. The single meal method was used. A sediment mixture followed by basolac morphology meal was observed fluoroscopically, and plates taken in the upright and prone positions afterwards. A plate was then taken at five hours and another at nine hours. Fluoroscopic examination was then made and a plate taken every twenty-four hours until the entire meal was evacuated, or impaction occurred.

TABLE III
X-RAY FINDINGS

Normal	68
Congenital low cecum	10
Abnormal	32
Congenital low cecum	13
Redundant colon	1
Cecal stasis	3
Colonic stasis	all

Absence of organic defects together with normal motility was considered normal. Normal motility consisted of the head of the meal at the hepatic flexure at five hours, mid transverse colon at nine hours, and complete evacuation at forty-eight hours.

We note that the x-ray findings were normal in sixty-eight cases. However, we find ten instances of congenital low cecum in these normals.

In thirty-two cases colonic stasis occurred. This varied from forty-eight hours to 336 hours. We also note that there were thirteen cases of congenital low cecum. In three cases cecal stasis was present. Only one case of redundant colon occurred in this series.

TREATMENT

On completion of the examination, the patient is shown the x-ray plates and the progress of the meal carefully explained. All other data are next discussed. Time is taken to explain to the patient the normal physiology and hygiene of the bowel. The full coöperation of the patient is absolutely necessary to ensure

successful treatment, and I consider this conference the most important part of the whole scheme of treatment. If the confidence of the patient can be secured and the treatment regime carefully explained, success is almost sure to follow.

The next step is to insist on complete withdrawal of all forms of catharsis. A small rectal syringe, four ounce capacity, is given the patient and instructions as to its use given. The syringe is filled with warm corn oil at bedtime, and the entire contents injected into the rectum while the patient is lying on his left side. This is repeated every night for the first week or two. An easy evacuation usually occurs every morning as a result.

DIET LIST

Beverages—Instant Postum, Cocoa, Water and weak Tea.

Breads—White Bread, Zwieback, Uneeda Biscuits and Soda Crackers

Eggs—Coddled, Poached, Soft Cooked or Raw.

Cereals—Cream of Wheat, Farina, Strained Oatmeal, Rice, Hcminy or Pettijohns.

Fats—Butter, Cream, Olive Oil, Broiled Bacon, Oleomargarine and Mineral Oil.

Soups—Soups made with Sweet Cream, Sour Cream or White Sauce and Strained Vegetables, such as Asparagus, Peas, Tomato, Carrots, Lettuce, etc.

Vegetables—Potatoes, cooked or baked; Asparagus Tips, Carrots, Beets, Peas, Cauliflower, Squash, String Beans or Wax Beans; may have pureed Corn, Peas, Split Peas and Celery. Creamed Macaroni or Spaghetti.

Meats—Scraped Beef, Broiled Lamb Chops, Broiled Tender Steak, Creamed or Broiled Chicken, Fish—Broiled, Baked or Cooked.

Desserts—Applesauce, Baked Apple without the skin, Canned or Stewed Peaches, Pears, Prunes (pureed), Custard, Gelatin, Junket, Simple Puddings, Tapioca, Ice Cream.

Avoid—Everything fried.

Avoid—All Spices and Condiments; Mustard, Vinegar, Ketchup, Horseradish, Relishes, Sauces and Gravies.

Avoid—All tinned, smoked and preserved Meat and Fish.

Avoid—All Pork, Veal and Game.

Avoid—All Tea, Coffee, Carbonated Waters and Soda Waters.

Avoid—All Pastries, Candies and Sweets.

Avoid—All Raw Fruits except Ripe Bananas.

Avoid—Raw Vegetables, such as Radishes, Onions and Olives.

Avoid—All kinds of Nuts.

Note—Lie down for one hour after each meal whenever possible. Drink from six to eight glasses of water daily. Take frequent walks out of doors. Never eat when excited or excessively fatigued.

A bland diet is then prescribed as shown herewith. At least six to eight glasses of water should be taken every day; meals should be taken leisurely, and all food thoroughly masticated. The diet is free from roughage and is poor in residue; therefore, plain agar-agar in doses of one tablespoonful with cereal is taken every morning. Cod-liver oil and Embo or

Beemax are given to insure sufficient vitamins. Coffee and tea is forbidden.

If there is marked spasm present, small doses of belladonna are given. At times phenobarbital in quarter grain doses is given before meals. No other medication is used.

Corrective exercises are then taught the patient. These consist of raising the legs on the abdomen while lying on the floor and alternating with raising of the trunk. Then, while standing, bend the trunk forward and backward and twist, then bend to the right and left. The exercises are to be taken in the morning on arising and just before retiring at night, about fifteen minutes each time. A habit time, preferably in the morning just after breakfast, is advised.

In some cases where there is marked emaciation or flaccidity of muscles, diathermy and sine wave currents, with tonic doses of Alpine light are given twice or three times a week.

The results in this series of cases has been very gratifying. Improvement in general health and relief of constipation has resulted in every case.

Relief from symptoms was gradual in most cases, but rapid in others. The average length of time required was about three months. Restoration to a normal diet and discontinuance of all medication and artificial aid concludes the treatment.

COMMENT

(1) In a series of 100 cases of constipation studied, symptoms characteristic of organic disease were commonly present.

(2) Roentgenological findings were normal in sixty-eight cases while disturbances in colonic motility occurred in thirty-two.

(3) Treatment featured by complete withdrawal of cathartics resulted in control of symptoms and restoration of normal bowel activity.

(4) Correlation of clinical and roentgenological findings offers a promising solution to the common and distressing state of constipation.

CLINICAL ASPECTS OF APPENDICITIS

FACTORS OF IMPORTANCE IN REDUCING ITS MORTALITY

By INGLIS F. FROST, M.D., Morristown, N. J.

The incidence of mortality in appendicitis is still very great, and while there has been a marked improvement in diagnosis and treatment during the past thirty years, there still seems to be a wide gap between surgical technique and surgical judgment, according to many authors.

The greatest improvement made is in an earlier diagnosis. We are all too familiar with the patients who come to us late after perforation and with a diffuse spreading peritonitis.

It is my purpose in this paper to review the factors that are important in the diagnosis and treatment of appendicitis, and to lay special stress on a type of appendicitis which carries a high mortality. I refer to the obstructive type first described by Professor Wilkie, of Edinburgh, who states that 90 per cent of the deaths of acute appendicitis are due to this type.

Both age and sex seem to be factors. It is decidedly a disease of young people; the male is attacked more often than the female, about four to one.

Predisposing causes are many, among which are indiscretions of diet, over-exertion, trauma, pregnancy, previous attacks, anatomical factors and association with other disease such as tonsillitis, typhoid fever or gastro-intestinal disturbances.

Of the exciting causes, the most important is the coprolith or fecal concretion. It is supposed that the coprolith is due to a previous mild inflammation which has interfered with the expulsive power of the appendix. This is followed by an over-production of mucus which dries on the fecal contents of the appendix. Lime salts then are deposited, causing the growth of the concretion which eventually, by its pressure, results in necrosis and bacterial infection, followed by perforation at the pressure site.

Clinically, appendicitis may be divided into acute and chronic cases. Acute cases may be separated, further, into the nonperforative and

the perforative; the latter may have a localized peritonitis or abscess, or a diffuse peritonitis.

The text-book picture of an attack of appendicitis is somewhat as follows: Usually, history of a sudden, sharp or crampy pain in the upper abdomen. Pain is always the first symptom and radiates down to the lower right quadrant. This is generally followed by nausea or vomiting and fever, with an accompanying rise in the leukocyte count. The physical examination shows muscle tenderness and spasm in the lower right quadrant and very often a hypersensitiveness of the skin over the eleventh and twelfth dorsal segments.

Unfortunately, this disease does not always present the text-book picture and we are often required to make a diagnosis with vague symptoms present. It is far better to err and operate early than to delay too long and risk losing the patient.

It is extremely important to understand the pathology of the type of appendix with which we are dealing and to recognize the symptoms associated with it. Our treatment will vary according to the type with which we are confronted.

The removal of the appendix as soon after the initial attack as possible is, of course, the ideal treatment. It must be kept in mind that often during the early hours of the attack the only complaint is a generalized pain across the upper abdomen; the localized tenderness and muscle guarding is a later manifestation.

In children it is always advisable to operate early as the appendix tends to perforate much earlier than in older people. This is especially true in children under 11 years of age.

An acutely inflamed appendix may perforate any time from 3 hours to 3 days after the first symptoms make their appearance. If perforation takes place, it is most often due to the obstructing type of appendicitis. It is important that the surgeon know the relative position of the appendix at the time of perforation. If rupture takes place into the retrocaecal fossa or on the outer side of the caecum, it is more

likely to form an abscess than if it perforates into the pelvis or, medially, in the region of the ileum. Diffuse spreading peritonitis or intestinal obstruction is more apt to follow this type of perforation.

The obstructing type of appendicitis with its high mortality gives a typical clinical picture so ably described by Howard M. Clute, as follows: "A sudden onset of pain which may waken the patient from sleep or may occur at any time in the course of his usual occupation. The pain, colicky in character, lasts for a little while and then quiets down; it returns after a time with even more severity and may then be persistent. An early and definite elevation of the white count is often seen. The temperature is usually normal. There is relatively little localized tenderness or spasm; this, we feel, is most important to recognize, since one may wait too long to detect the spasm and tenderness before urging operation in this type of case. In fact, it is our belief that the diagnosis of acute appendicular colic may well be made upon this typical history of pain in the lower abdomen often referred to the region of the umbilicus without further localized symptomatology of the condition than tenderness over the appendix area."

A recent article in *Surgery Gynecology and Obstetrics* suggested the following rules as safe procedures to follow in selecting cases for operation.

- (1) Patients with subsiding inflammation or those with recurring subacute appendicitis: the interval operation.

- (2) Patients with circumscribed abscesses: simple drainage at the most favorable moment and with minimal exploration.

- (3) Patients with Wilkie's obstructing type with its threat of dangerous gangrene or patients with the acute inflammatory type seen in its early phase: earliest possible operation.

- (4) Patients with late, uncertain type with distention and symptoms indicating intestinal obstruction: a consultation between surgeon and general practitioner to determine whether immediate action or delay would involve less risk.

Spinal anesthesia has been a decided help to the surgeon as a quiet abdomen is obtained with relaxation of the abdominal muscles.

The right rectus incision with the muscle retracted and with an incision large enough to view adequately the infected area is used. The next step is the introduction of a pad towards the mesial side to hold away the omentum and the small intestine, with other pads to protect the surrounding areas from contamination.

Many surgeons feel that it is better practice not to invert the stump, but to doubly ligate the stump and tie the mesentery over it after the usual cauterization.

In closing the wound, it is well to start at the top in order that the pad, when withdrawn, will carry the omentum down with it, thus covering the infected area.

Soft cigarette drains are preferable to hard rubber; these should be replaced in a few days by catheters.

One of the post-operative complications that surgeons dread is a generalized peritonitis with the possibility of an intestinal obstruction developing; in these conditions, the Murphy-Ochsner treatment gives the best results. This treatment is familiar to all of us. The patient is put in an extreme Fowler position and is given absolutely nothing by mouth. Large doses of morphine are given to reduce peristalsis to a minimum so that walling-off may take place as rapidly as possible. Vomiting is controlled by washing out the stomach, and large amounts of fluid are given either intravenously or by means of clysis, using a 5 per cent glucose solution.

Constant watching for the "silent" abdomen is necessary, and, if symptoms of obstruction or ileus arise, the question of performing an enterostomy must be considered.

An x-ray picture of the abdomen is of material help especially if obstruction is present; coils of small intestine may be seen to be dilated. It is in this type of case that enterostomy gives best results.

The mortality of acute appendicitis is still too high. The lowering of this mortality rests, first, with the medical practitioner in making an early diagnosis; and, secondly, with the surgeon in operating as soon as possible, in understanding the pathology of the case and in carrying out proper procedures in both his operative technic and in his after-treatment of the patient.

SYMPOSIUM ON JAUNDICE

Abstracts of Four Papers Constituting the Scientific Program of the Hudson County Medical Society, February 6, 1934

THE MEDICAL ASPECT OF JAUNDICE THE VALUE OF X-RAY IN GALL-BLADDER DISEASE

By THOMAS J. WHITE, Jersey City, N. J.

Jaundice may be divided into three classes according to its cause:

- (1) Extra-hepatic due to obstruction, in the common bile duct as by a stone, carcinoma, or stricture.
- (2) Intra-hepatic (toxic or infectious), the result of a disease process confined to the liver itself.
- (3) Hemolytic, due to conditions of the blood.

What may be termed secondary hemolytic jaundice is sometimes seen in a variety of conditions such as after blood transfusions, and in septicemia and chronic anemia.

The essential point in diagnosis is to determine whether or not the treatment should be medical or surgical. In order to group a particular case, clues are to be found in the history, the physical examination and the results of laboratory tests.

The history may suggest the cause. Arsphenamine treatments, cirrhosis of liver, previous attacks of gall-bladder colic, and indigestion are to be considered. A former attack of hematemesis or trouble from bleeding hemorrhoids, may be related to an unsuspected cirrhosis. The mode of onset, and the development of pain are significant.

The importance of a careful physical examination is to be emphasized. Great loss of weight is suggestive of malignancy. Acute liver necrosis may develop insiduously. The examination should include the whole body. Rheumatic heart disease may be a factor back of jaundice or a carcinoma elsewhere may metastasize in the liver or the bile duct. Laboratory examinations usually give less information than a detailed history and physical examination. If hemolytic jaundice is excluded, the really important tests narrow down to three.

(1) The reaction to the Van der Bergh test, whether direct or indirect.

(2) The quantitative Van den Bergh test or icterus index. If this test is made every two or three days, a graphic curve can be constructed, showing the bilirubin level. A fluctuating level suggests a benign condition, while an increasing level is suggestive of liver cell degeneration or obstruction due to carcinoma.

The presence or absence of bile and blood in the intestine may give important clues.

Tests for liver function are numerous, but no satisfactory one has been found. The excretory function as expressed by the volume of serum bilirubin furnishes more definite information, especially if it is determined often. Urine tests give little information, but the presence of urobilin and tyrosin crystals in the urine may be a warning sign of severe liver damage.

By WILLIAM WALLACE MAVER, M.D.,
Jersey City, N. J.

The practical value of the Graham test (the excretion of a dye opaque to x-rays after its injection into the body) is admitted by all. It has become a routine examination in Roentgen procedure, and has greatly enhanced the value of x-ray in gall-bladder diagnosis.

Prior to the use of the dye in gall-bladder Roentgenology, the field of observation was limited to those diseased gall-bladders which contained stones of sufficient lime content to render them visible on an x-ray film, or to several indirect and indefinite signs of reflex gastric irritation.

In order to determine the value of x-ray in gall-bladder disease, it seems advisable to divide all cholecystographic examinations into two main groups as follows:

(1) Those examinations that are classified as stone positive or shadow negative. These are about 90% correct.

(2) All those examinations that are classified as demonstrating a well defined image of a normally functioning gall-bladder.

In the second main group of cholecystographic examinations are included those in which a well defined image of the gall-bladder can be demonstrated in the x-ray film. In these cases, the gall-bladder fills and retains the dye-impregnated bile, and in later fasting examinations, evidence of concentration of the dye can be recorded. The emptying of the gall-bladder may not be as prompt as in a perfectly normal viscus, but in the routine procedure the impression obtained is that all of the functions of the gall-bladder are performed normally. In this second group, approximately 27% of the gall-bladders reported normal are found to be definitely pathological by the surgeon.

Normal emptying function and freedom from pathology are not synonymous in the gall-bladder. Therefore, if the clinical evidence points to a gall-bladder lesion, this evidence should outweigh the roentgenologist's statement relative to gall-bladder function, and adequate steps should be taken to prove or disprove gall-bladder disease.

Taken by and large, the accuracy of the Graham test renders it a valuable adjunct in the diagnosis of gall-bladder lesions. By its aid, the visibility of gall-stones has been increased from about 50% to 81%, and as we learn more about the complexities of the biliary circulation, we may more intelligently apply that knowledge to the intricacies in behavior of this organ and its passages in their normal and complicated pathological states, as observed in this rather unique Graham test.

THE CAUSE OF SOME UNEXPECTED DEATHS FOLLOWING CHOLECYSTECTOMY

By FRANK J. McLOUGHLIN, M.D.,
Jersey City, N. J.

The sudden and unexpected death of a patient following cholecystectomy, when preoperative study revealed no factors involving more than the average risk, is startlingly dramatic. That such deaths are not infrequent is amply demonstrated by a survey of the recent literature which contains the reports of similar experiences in the writings of numerous surgeons in hospitals scattered throughout the country.

Heyd, in 1931, in analyzing the mortality in a series of cases at the Post Graduate Hospital in New York City, "was impressed with a small group of fatal cases in which the cause of death could in no way be placed under the obvious types of mortality", and suggested for them the term "liver deaths".

The discussion that followed the presentation of this paper at the meeting of the American Medical Association revealed no unanimous opinion of the cause of these fatalities. The suggested causes, namely, ether, anaesthesia, alkalosis, dehydration, and operation in the acute stage certainly fall far short of any satisfactory explanation.

Study of these patients for clinical and laboratory evidence of alterations in the known physiological activities of the liver does not show any cessation in these functions; blood sugar determinations show no impairment of glycogenesis; urea formation was unimpaired, and the stool contained bile.

The speaker feels that, based on the most recent observations and laboratory exploration, the so-called "liver death" is due to some toxin elaborated in a diseased liver, which toxin acts directly on the kidneys, producing profound degenerative changes in these organs. This type of death resembles more closely the so-called hepatic exhaustion outlined by Heyd, and should be differentiated from the deaths occurring after operations on the bile ducts.

The speaker's interest was sufficiently aroused by this theory to undertake an analysis of a series of consecutive cholecystectomies occurring on his division at St. Francis Hospital, and he found that of the four deaths that occurred, two showed a clinical course quite similar to the reported observations.

This syndrome might well be considered in some detail. In almost every case, the history of long-standing gall-bladder disease with the frequent occurrence of colic was observed, yet the physical examination revealed no defects that would lead to the assumption that operation carried any unusual risk. Laboratory data, including blood and urine studies, failed to reveal any evidence of kidney disease. The operations were carried out without any undue trauma, and in accordance with accepted technical standards. The patients were returned from the operating room in satisfactory condition, following either general or spinal anaesthesia.

After operation, there was a progressive rise in temperature, with markedly inadequate urinary output in spite of the administration of sufficient fluids. The scanty urine, on examination, showed the presence of albumin, casts, and red cells, while the blood showed abnormally high levels of non-protein nitrogen, urea and creatinine.

Death might occur with progressive elevation of temperature and rapidly decreasing urinary output, or there may be an interval of several days in which the temperature remained high, the urinary output, although it increased somewhat, never reached a satisfactory level.

The patients showed slight abdominal distention, and bowel function was usually satisfactory. Mental dullness, increasing to delirium of the mild type that appeared definitely uraemic, occurred; and finally a terminal rise in temperature.

Post-mortem examination showed no evidence of infection in the abdominal cavity, and aside from the pathological state of the liver and kidneys, was entirely negative.

It is difficult to determine, by any preoperative tests, which of the cases coming to operation are likely to develop this unusual sequence of events leading to fatality.

The determination of the functional efficiency of the liver by any known method is difficult and unsatisfactory because of the unusual functional reserve and remarkable regenerative power of that organ. The only tests that are considered to be of any value are (1) the bromsulphalein test of Rosenthal and White, in which retention of more than 50% of the dye after five minutes or any of the dye after thirty minutes indicates hepatic damage, and (2) the phenoltetrachlorophthalein test developed by Graham in investigating this type of death. This is the dye used for cholecystography, and when given intravenously for this purpose, can also be used as a test of liver function. Any retention of over 50% in the first hour should be considered as indicative of some degree of liver involvement.

Graham has utilized this test in an attempt to select those cases in which there is possibly sufficient liver involvement to indicate increased operative risk, and those showing dye retention are placed on a high carbohydrate diet for some days prior to operation, with the administration of glucose in large amounts, preferably intravenously, before and after operation.

It is to be hoped that the adoption of these precautions which, with our present knowledge are all that can be suggested, will help in reducing the frequency of these unexpected fatalities.

THE SURGICAL MANAGEMENT OF OBSTRUCTIVE JAUNDICE

By EARL J. HALLIGAN, M.D.,
Jersey City, N. J.

Obstructive jaundice, otherwise known as extra-hepatic or surgical jaundice, is the result of mechanical occlusion of the bile passages. Few diseases have been more thoroughly studied. Reports of the experimental work and clinical observations may be found in the literature for the past one-

hundred years, but the greatest advances have been made in the last few years, due to the combined efforts of physiologists, pathologists, and surgeons.

Although the accepted tests of hepatic function in obstructive jaundice, such as dye retention test and the Van den Bergh test, yield valuable information concerning the clinical condition of the patient, they do not afford an accurate indication of the amount of temporary or permanent hepatic injury, caused by bile salts and infection, and increased biliary pressure.

The chief complications clinically in obstructive jaundice are: hepatic insufficiency, hemorrhage, renal insufficiency, anemia and emaciation. Dr. Halligan then discussed these complications in detail.

Hepatic Insufficiency: In the presence of such pathologic changes in the liver, it is not surprising that disturbances of hepatic function occur. There are no precise means of estimating the degree of injury to the liver. Although recent laboratory refinements give considerable aid in this direction, one's clinical estimation must usually be the basis of surgical judgment; and this is influenced by the duration and degree of jaundice, the presence or absence of infection, hemorrhagic tendencies, the size of the liver and the general nutrition of the patient. Accompanying the foregoing pathologic changes, are definite evidences of alteration of hepatic function. The content of bilirubin and bile salts in the blood is increased. There are alterations of sugar metabolism.

Undoubtedly, the so-called detoxifying function of the liver is decreased, and lastly, there is marked retention of the dyes used for tests of hepatic function, although as a rule, this is chiefly dependent on the obstruction rather than the parenchymal injury to the hepatic cells.

These factors all indicate decreased hepatic function, the amount of impairment of function being dependent on the degree and duration of the biliary obstruction and the amount of infection in the biliary system.

Hemorrhage: This disturbance of blood coagulation, with a tendency to bleed in jaundice, has long been known. Spontaneous hemorrhage in almost all of the organs has been seen, and this may be of serious consequence, especially when bleeding occurs in the alimentary or urinary tract, or the brain and spinal cord.

Postoperative hemorrhage in the past, Dr. Halligan brought out, has been the cause of death in 58% of the cases that die during the first week after operation for obstructive jaundice. This has been reduced to less than 10% with present methods.

Prediction of Hemorrhage: There is no reliable laboratory test by which it may be predicted whether or not a jaundiced patient will bleed. In general, patients who have obstructive jaundice a long time are more apt to bleed than those who have been jaundiced a few days.

The increased rapidity of sedimentation rate of red blood cells indicated a definite tendency to bleed. As an index, the normal sedimentation rate

at the end of 30 minutes is used, and when the cells settled more rapidly than 30 m.m. in 30 minutes, there was a definite tendency to bleed; and if the rate was slower, there were no hemorrhagic tendencies. Although it has failed in a few instances, this test is a far more accurate index of the hemorrhagic tendency than coagulation time.

Glucose and saline solution intravenously, and the transfusion of whole blood are the best methods for the prevention and treatment of hemorrhage in these cases.

Renal Insufficiency: The kidneys are early affected and renal insufficiency is a dangerous and disturbing complication. The physiology of the kidney and liver are intimately and inseparably related, for the maintenance of the chemical status of the blood components, and life depend on their coöperation. Impairment of function of one throws an added burden on the other; and if both are severely diseased, the results are obvious.

Renal insufficiency in jaundice is caused by several factors, but opinions differ as to which is most harmful. Fortunately, measures directed towards relief of hepatic insufficiency are also indicated in renal insufficiency, namely, fluids and carbohydrates, particularly glucose in saline intravenously.

Selection of Time for Operation: The selection of a favorable time for operation is of great importance, and is one of the chief factors in decreasing the mortality in late years. All cases of biliary obstruction are bad risks and stand operation poorly. If operation is delayed for a week or ten days, and proper treatment is administered, the patient will stand the operation better. During the delay, the various laboratory tests are made and the patient prepared. The serum bilirubin is determined (this probably gives us the best information as to hepatic function as a whole). With an increasing bilirubin, the obstruction is becoming more and more complete, the liver damage is increasing, and one must weigh carefully the risk of operation. It is far better to wait for a decrease in serum bilirubin, or until such a time as the serum bilirubin has reached a constant level.

Renal function is determined at this time by blood urea tests daily, and phenolsulphonethalein and concentration tests. Prolonged coagulation time, rapid sedimentation rate, and any other evidence of cutaneous or other hemorrhage are indications for delaying operation, and transfusions are to be given if indicated. Fever is another reason for delay, the speaker stated, and he prefers to wait until this has subsided. During this time, preoperative treatment is instituted and the disadvantage of the delay is more than offset by the advantage of sufficient preoperative treatment and selection of the optimum time for surgery.

Preoperative Treatment: The preoperative treatment of the patient as carried out at St. Francis Hospital is done by giving the patients as much fluid, particularly water and fruit juices, as they can take by mouth, and glucose and carbohydrate in the form of a high carbohydrate diet. They are given a small amount of protein. In addition, intravenous salt solution with 10% glucose is given, or hypodermoclysis of 5% glucose in

saline. At least 2,000 c.c. of saline with 75 to 125 gr. of glucose are given twice daily, intravenously or subcutaneously.

In cases with a tendency to bleed or if jaundice is of long duration, the patient is transfused one or more times, both preoperatively and postoperatively. On other cases, when the patient is jaundiced, transfusion is withheld until the indication arises.

The spinal anesthesia is ideal in the fairly good risk, and in the bad risk, local or regional alone, or with nitrous oxide or ethylene is best. He explained that the establishment of adequate biliary drainage was the first and most important feature of operation; however, in the bad risk case, too much must not be done.

Postoperative Treatment consists of fluids, particularly saline and glucose intravenously, at least 3,000 c.c. daily; the use of as little morphine as possible, and careful watch for complications.

Postoperative complications are infrequent if the patient is seen early enough and adequate biliary drainage is established. In cases that have been seriously jaundiced for a long time, and occasionally a postoperative reaction, so-called liver shock, occurs some hours after operation. It is marked by a tremendous depression of all vital functions. Blood pressure drops to 80 m.m. systolic, or lower, pulse becomes slow and soft; the patient is apathetic, asthenic and impasive or semi-conscious. He may then grow rapidly worse and death occurs. The cause is unknown, but Ravden thinks it is due to depressor substances liberated from damaged liver cells when obstruction is relieved.

Treatment of Liver Shock: Intravenous saline, glucose and adrenalin nad stimulants are given as indicated; Trendelenberg position.

Hemorrhage is the most serious complication, and usually whole blood transfusion protects the patient from bleeding for three to five days.

Daily sedimentation rates will indicate the probability of hemorrhage.

As high as twelve transfusions have been given in postoperative bleeding of this type, with a successful outcome.

Renal insufficiency occasionally occurs, and is denoted by raising non-protein nitrogen and diminution of urinary output. Biliary drainage lessens and jaundice deepens, and the patient becomes uraemic.

Uremia is best managed by the administration of glucose and saline intravenously. Often 200 c.c. of 20% glucose will stimulate the kidney secretion immediately.

Hepatic insufficiency comes on two to eight days postoperatively, with marked increase of a thin pale flow of bile. The patient grows weaker, the pulse loses volume, the temperature becomes subnormal, and the patient becomes restless and irritable. Fatigue and muscular weakness develop; regurgitant vomiting follows; jaundice does not deepen much, but pallor ensues. The patient finally becomes drowsy and stuporous, and dies.

The urinary output equals the intake of fluids, and blood urea stays the same. The treatment again is glucose and fluids, particularly intravenously.

Obstructive jaundice is one of the most exacting conditions we have to treat. It demands early and thorough preoperative treatment, careful and conservative operative judgment, and meticulous postoperative watchfulness. The results are as fully dependent upon the preoperative and postoperative treatment as upon the operation itself.

PUBLIC RELATIONS OF MEDICINE THE PHYSICIAN AND A HEALTH-CONSCIOUS PUBLIC

By WILLIAM H. ROSS, M.D., Brentwood, N. Y.

Abstract of an address before the Essex County Medical Society, January 11, 1934.

Medical service is available in abundance, and yet whole groups of people suffer from its lack, just as they go hungry in the midst of a surplus of farm products. The equitable distribution of medical service is a sub-division of a universal problem of the distribution of all kinds of services and opportunities.

Society has put medicine on the defensive in demanding services for which adequate provision has not yet been made by either lay organizations or the physicians. Lay health organizations have loudly announced the revolutionary proposals of health insurance and state medicine as means for the equitable distribution of medical services. On the other hand, the medical profession has sought to secure the evolution of a system based on the extension of methods of practice which have stood the test of time and experience.

The initiative in solving the problems of com-

munity medicine has been assumed by the lay organizations. The responsibility is now upon the medical profession to evolve a better plan—which it can surely do. Medicine cannot remain on the defensive. It must announce its own plan for aggressive action if it is to win.

The plan which the medical profession offers is that of leadership and coöperation in both the diagnosis and the treatment of the ills and defects in the distribution of medical services. Physicians plan to deal with the problems arising in the local communities and solve them one by one as they appear, and as the people are prepared to adopt the solutions.

The most valuable agency for solving the problem of equitable distribution of medical service is the public relations committee of the county medical society. This committee deals with the mutual relations which exist between the group of physi-

cians which constitute the medical profession and the lay groups consisting of the numerous welfare organizations, both official and lay, which touch upon health.

With this introductory statement of general principles, I wish to summarize what the Medical Society of Suffolk County, New York, has done by asserting the leadership of the medical profession in all lines of community medicine.

Beginning in 1912, before the public mind was confused by discussions of social trends and medical exploitations, the society has assumed the responsibility for every form of local health problem. It did this along four lines.

(1) The leaders in the society began an effort to bring every qualified physician to its membership; and ever since that time it has kept over 90 per cent of the doctors on its rolls.

(2) Every member was given some part to do, or called upon to give some special service. The pride of having rendered a service to the society makes a member take a personal interest in its welfare.

(3) Individual doctors have represented the society on every public health organization in the county. They have done this so successfully that they have filled the principal offices and chairmanships in nearly every organization.

(4) The society has always had on hand a major project which it has promoted. This has probably been the most potent factor in keeping the society in a commanding position before the doctors and the public. The physicians have felt that the society always had a definite objective in which the public was interested.

An enumeration of the projects which were promoted by the Suffolk County Medical Society will illustrate the lines of work which are open to any other county society.

(1) The public health activity of the Suffolk County Medical Society was initiated at a meeting of the society in 1912, when it voted to support a campaign for the establishment of a county tuberculosis sanatorium. This campaign was conducted almost entirely by the physicians, and with very little help from any outside agency, for those days were before the special activities of the State Health Department in those lines. The project was successfully accomplished. The sanatorium was opened in 1916 and has been enlarged from time to time; and when the present buildings are completed, it will have a capacity for 200 patients.

(2) The society has maintained a system of tuberculosis clinics in which every case is referred by a physician, and a report is sent back to him. No other form of tuberculosis clinic has ever been even considered.

(3) The society instituted a study of the indigent chronic cases in the county, and started an agitation which resulted in the establishment of an infirmary at the county almshouse in 1920. The facilities have been extended and are now on the program for further extension.

(4) The society established a monthly bulletin called the "News Letter", in 1922, for the purpose of carrying articles of information regarding public health projects. The articles were informative and descriptive of the projects under promotion by

the county society and were widely copied in the local newspapers. The "News Letter" is the principal means of publicity used by the society in the promotion of its projects.

(5) The outstanding accomplishment of the Suffolk County Medical Society was the establishment of a County Health Department in 1928 after a campaign of two years which was conducted by the Medical Society alone. The strength of the movement was the fact that the practicing physicians and local health organizations which they dominated were the only agents engaged in its promotion. The Board of Supervisors and the people were unanimous in supporting the unified wishes of the medical profession.

The County Health Department has amply justified the expectations of its promoters. Its work is carried on with the full coöperation and support of the practicing physicians. No clinics are conducted except those which are unanimously approved by the physicians and in which local physicians are paid for their services.

(6) The County Society in 1928 undertook the educational work in Cancer Control. A large committee was organized. This work has been carried on actively ever since by physicians giving talks and holding diagnostic clinics. A deep x-ray therapy equipment has been installed in two of the general hospitals of the county.

(7) The County Society established a committee on economics in 1930, with members willing to work. They first established friendly coöperation with the Department of Public Welfare, then standard agreements were made and a simple fee list set up. The committee acts as a Board of Arbitration between the doctors and the Welfare Commissioner on all disputed questions of bills or relationship.

The agreements were that, the family physicians of the patient shall be employed as in private practice; the physician shall obtain authorization for treatment of a patient from the Welfare Department. This authorization must be renewed every two weeks for continued attendance. In an emergency, the physician shall give the proper treatment and obtain authorization for his treatment within forty-eight hours.

Ninety-six doctors in the county have done welfare work during the year 1933 and were paid an average of \$396 each. Fourteen per cent of the population of the county were given medical care under the Public Welfare Law at a cost of \$70,000, about half of which was paid to the hospitals, and half to the physicians.

A concept twenty-five years ago expressed by the County Society regarding its public responsibility, and the exercise of its leadership in meeting health problems, have resulted in public confidence of the county in its medical profession and have caused the public to look to the local profession to take care of the county's medical problems.

We are in the midst of great changes in our economic life. The relation of medicine to them will be determined by the attitude of society toward medical care and health services for all people. Medicine can direct the trends in medical care and its relationship; and the available arm of its organization is in its Committees on Public Relations.

SYMPOSIUM ON BRONCHIECTASIS

Abstracts of Three Papers Constituting the Scientific Program of the Atlantic County Medical Society, February 9, 1934

THE DIAGNOSIS AND TREATMENT OF BRONCHIECTASIS: ROENTGENOLOGIC ASPECTS

By JOHN T. FARRELL, JR., M.D.,
Philadelphia, Pa.

The x-ray signs of bronchiectasis at the onset consist of filamentous shadows extending from the root areas downward and laterally into the lower lung fields. Progression leads to increase in the width and extent of these linear markings.

Bilateral bronchiectasis is usually basal and associated with generalized disease of the respiratory mucosa. Frequently, though not always, clinically or roentgenologically demonstrable disease of the accessory sinuses accompanies it.

The finding of bilateral lower lobe bronchiectatic changes is an indication for examination of the accessory sinuses, both clinically and roentgenologically. Often the pulmonary condition will be improved when the disease of the sinuses is corrected.

When due to bronchial occlusion, bronchiectasis is usually unilateral. The roentgenologically recognizable changes depend upon the cause, the size of the occluded bronchus, and the duration of the closure and the complications. Following prolonged occlusion of a main bronchus by a foreign body or neoplasm, cavities develop secondary to suppurative changes in the collapsed lung. These vary in size and are always surrounded by densely indurated lung from which air is excluded.

Following the introduction of iodized oil by Sicard and Forestier in 1922, great steps have been made in the diagnosis of pulmonary lesions. We have used almost exclusively the bronchoscopic method of introducing the oil. In this procedure the bronchoscopist introduces the opaque material by direct vision into the area of known or suspected involvement after aspiration of the secretions. Occasionally, the oil is introduced under fluoroscopic guidance, but this is unusual and is only done when an upper lobe is involved. The bronchoscopic method offers several advantages; first, the bronchoscopist is able to examine the bronchial branches to determine their normalcy and locate the bronchial subdivision from which the secretions are coming; second, it is possible to empty the cavities by aspiration before introducing the opaque oil; and third, the oil is introduced directly into the involved area and manipulation of the patient is unnecessary.

X-ray studies are made in postero-anterior and lateral planes, and it is our practice to make one roentgenogram on the Potter-Bucky diaphragm to bring into bold relief the filled cavities.

Bronchiectasis as seen roentgenologically is of two main types, saccular and cylindric. Other types are described, but they are of academic rather than of practical interest. The saccular type is the more common, and in it the oil collects in multiple pools. The cavities are surrounded by a varying amount of tissue of increased density, a fact differentiating the disease from other conditions. In the less common cylindric type the bronchi are stemlike in appearance, and are not surrounded by so greatly indurated tissues as is seen in the saccular type.

The distribution, number, size and extent of the collections of iodized oil seen on the pneumonogram depend upon the type of the disease, and its extent, and location.

The changes of bronchiectasis must be differentiated roentgenologically from those of several other pulmonary lesions, notably basal tuberculosis, pulmonary abscess, the basal changes of asthma, congenital cystic disease of the lungs, passive pulmonary congestion, and basal inflammatory lesions secondary to aspiration of foreign particles.

THE DIAGNOSIS AND TREATMENT OF BRONCHIECTASIS

By LOUIS H. CLERF, M.D., Philadelphia, Pa.

The diagnosis of bronchiectasis is not always easy; particularly if the involvement is of moderate degree. While the findings on the basis of the history, physical examination, roentgen evidence, and sputum studies may often be sufficient to warrant a positive diagnosis, other diagnostic aids become necessary in many cases.

A diagnosis of bronchiectasis is, in itself, often inadequate since bronchiectasis is commonly secondary to a preëxisting lesion. This is particularly true in cases of obstructive bronchiectasis. It is, therefore, important to secure all available data in a study of these cases.

The frequent concomitance of nasal accessory sinus disease and bilateral lower lobe bronchiectasis is not coincidental. In a series of slightly less than 200 cases of bronchiectasis this relationship was noted in over 80 per cent of cases. It is very probable that sinus disease is a predisposing etiological factor in those patients who frequently contract tracheobronchial infection secondary to head colds.

Bronchoscopy plays a very important part as an aid to the thoracic surgeon in the care of cases of bronchiectasis. It is of aid in the diagnosis and localization of the area involved and is of value in the pre- and post-operative treatment. Success in the treatment of obstructive bronchiectasis is often dependent on bronchoscopy.

Treatment—The care of bilateral bronchiectasis is not particularly satisfactory. Foci of infection, notably sinus disease, should receive appropriate treatment. Drainage of secretion to prevent stagnation and decomposition with resultant changes in the bronchi and surrounding lung tissue presents the greatest difficulties. Postural drainage, faithfully performed, is very helpful. Many of these cases are aided by an occasional bronchoscopy. Intratracheal instillation of medication by the indirect method is of value in certain cases. No particular merit can be ascribed to any medicament. The outlook in inoperable forms of bronchiectasis is not good. In the untreated case there is a tendency for the disease to be progressive.

In reviewing the causes of bronchiectasis, it is quite obvious that certain of these cases can be prevented. Prompt recognition and appropriate treatment of the various forms of bronchial obstruction, so-called unresolved pneumonia, post-operative pulmonary complications, acute pneumonia and nasal sinus infection with tracheo-bronchial symptoms would be far more productive of benefit than all of our futile attempts to restore to normal function a dilated, tortuous, fibrous-walled, bronchial tree.

SURGERY IN THE TREATMENT OF BRONCHIECTASIS

By JOHN B. FLICK, M.D.,
Philadelphia, Pa.

The surgical procedures for the treatment of bronchiectasis fall into two classes:

(1) Those causing a collapse of the diseased part of the lung; such as artificial pneumothorax, phrenic paralysis, and extra-pleural thoracoplasty.

(2) Those for removing the diseased portion of the lung, consisting of lobectomy and cautery pneumolectomy.

Lobectomy is the ideal treatment, but the high mortality has made surgeons hesitate to advise it. Recently the mortality has been lowered in carefully selected cases, and probably before long will compare favorably with that of other operations for equally serious conditions.

In the one-stage operation, a long incision is made in the general direction of the ribs and the sixth or seventh interspace is opened. The subsequent exposure is much enlarged by dividing the ribs adjacent to the selected interspace near the vertebral ends and spreading them apart. The diseased lobe is freed completely by dividing adhesions and severing the pulmonary ligament, a snare of heavy cord is passed around the lobe near the mediastinum and the loop drawn tight in an instru-

ment designed for the purpose. This controls the blood supply, obstructs the bronchi and provides a solid support during suture of the pedicle. After the lobe is cut away obvious vessels are ligated and the pedicle made secure with running sutures of catgut. A fenestrated tube is introduced through an interspace for the purpose of instituting closed drainage, and the operative wound is closed in layers. The remaining lobe expands rapidly, obliterating the dead space and becomes adherent. Infection, when it occurs, is limited to a small residual cavity and a large empyema is obviated.

John Alexander, of Ann Arbor, advocates lobectomy in stages. He reports eighteen total lobectomies with three deaths (16.66 per cent). Twelve of these were operated upon according to the principles developed by him with two deaths (16.66 per cent). Only the last six patients have had the benefits of the fully developed technic, and none of these have died.

The pathological changes that occur in the lung in bronchiectasis are such that a cure cannot be hoped for with conservative measures except in early cases when the degree of dilatation of the bronchi is slight. The course of the disease frequently is progressive and the complications many and serious.

Findlay and Graham conclude that the prognosis in bronchiectasis in childhood is grave, as the condition usually steadily gets worse and leads to a fatal termination.

In adults the best that can be said of prognosis in established bronchiectasis, when permanent damage has occurred and the dilatations have become fixed, is that the patient may be relieved of symptoms by conservative treatment for varying periods of time, but that the disease usually is progressive. Such complications as bronchopneumonia, empyema, pulmonary abscess, abscess of the brain, and amyloid disease are not uncommon. The association of cerebral abscess and pulmonary disease has long been known. This combination of lesions was fully investigated by Schorstein. He found that cerebral abscess was the terminal factor in about 20 per cent of sixty-three collected postmortems on patients suffering from bronchiectasis.

Bronchopneumonia is probably the most frequent complication and the most common cause of death in this disease.

Obviously, all patients with bronchiectasis are not suitable cases for radical surgical procedures, nor are such procedures always advisable. It is safe to say of the advanced cases that many of them at some time during the course of the disease would have come within the sphere of radical surgery had an early diagnosis been made.

Artificial pneumothorax, phrenic paralysis, thoracoplasty, and cautery pneumolectomy no doubt will always have a place in the treatment of bronchiectasis; but with an early and more exact diagnosis, made possible by modern methods and improvement in technic of the operation, a greater number of cases of bronchiectasis will be found suitable for lobectomy and will be subjected to that operation.

THE DIAGNOSIS AND TREATMENT OF BRONCHIECTASIS

By WRIGHT MACMILLAN, M.D., Passaic, N. J.

Abstract of a paper read before the Passaic County Medical Society, October 12, 1933.

Until the publication of the work of Forestier and Sicard in 1922, the diagnosis and treatment of bronchiectasis were without certainty or satisfactory results. These workers, by their use of iodized oil as an x-ray contrast medium and a therapeutic agent, have opened the door to scientific management of this very common disease.

The cause of this disease is still a matter of doubt. Stenosis or obstruction of the bronchial tubes, and also atelectasis, may produce bronchial dilation; but there is still the feeling that this is not what we mean by the disease, bronchiectasis. It is a syndrome embracing etiology, course, and microscopic pathology, rather than a classification based on a single gross abnormality, the dilated bronchial tube.

We see bronchiectasis following chronic bronchitis—or is the bronchitis the early stage of bronchiectasis? Bronchiectasis follows chronic sinusitis, and some of the changes from chronic sinusitis in the nose and pharynx are suggestively similar to the changes in the bronchial tubes. In the earlier stages in both locations there are congestion, edema, leukocytic infiltration, and hypertrophy. On the mucosa of the bronchial tubes there may be polypoid growths with hemorrhagic tendency. Atrophic rhinitis has the identical pathological findings of late bronchiectasis, the difference in tissues being considered: a long-standing mixed infection which may contain proteolytic bacteria capable of releasing a foul odor, atrophic and injured mucous membrane; congestion; wandering cell infiltration; and gradual atrophy of specialized tissue, as, muscle, mucus glands, cartilage, and bone. The highly resistant fibrous tissue remains. The nasal mucosa loses its succulence, and the bony framework of the turbinates withers; the bronchial tube loses its supporting muscle and cartilage and becomes a more yielding fibrous sac.

Reasoning *a priori* a very strong case can be made out as a causing factor against sinusitis. We know that iodized oil placed in the pharynx readily enters the lung. Purulent mucus from a sinus would obviously do the same. The normal lung would conceivably develop the changes found in bronchiectasis if constantly made the reservoir for toxic, septic products. The same process which causes an atrophic rhinitis is seen to cause an atrophic bronchitis.

The pathology is in the left lobe in the great majority of cases.

The diagnosis in the early stage is hardly possible without the x-ray and radiopaque oil. The symptoms are recurrent bronchitis or often chronic cough, with or without expectoration. The only physical signs may be persistent localized râles. Ochsner found in a group of college students with chronic cough that 92 per cent had bronchiectasis as shown by the x-ray after injection of iodized oil.

The advanced cases may be diagnosed on the history of chronic cough, copious expectoration,

fetid sputum, and absence of tubercle bacilli from the sputum. Many cases of this advanced type are receiving treatment in tuberculosis sanatoria under a mistaken diagnosis. Iodized oil injections and x-ray make the diagnosis of these cases easy and certain.

Five or six methods of injecting the oil and several special instruments have been devised, but the supra-glottic intralaryngeal method is the one which seems to meet the logical requirements of the pro-



Fig. 1—Upper lobe injected showing bronchiectasis.

cedure. The work of the pioneers was done with Lipiodol, Lafay. This was also my choice until the last few months when Lipiodine, Ciba, was used and found to be less disagreeable in taste and odor.

The method of instilling the oil is as follows: With the patient seated, the oropharynx, epiglottis, and larynx are anesthetized with 10 per cent cocaine or 2 per cent nupercaine. The patient grasps his tongue with gauze and holds it forward. He inclines his body toward the side to be injected. The operator, with a laryngeal mirror and curved laryngeal syringe, injects 20 c.c. of warm iodized oil directly into the larynx. Both sides may be injected at one sitting. If the patient coughs before the picture is taken, the result will be a scattering of the oil into the alveoli and obscuring of the bronchial shadows. Therefore the x-ray room should be near and the machine and cassette ready to take the picture at once. The radiation should be three times the amount for an ordinary lung plate.

In studying the upper lobes, the patient should be injected while reclining on the x-ray table, propped on two pillows on the side in question. A minute after the injection is completed, the shoulder is lowered off the table to allow the oil to flow

into the ascending bronchial tubes. He is then quickly replaced on the table and the exposure made immediately. A tilting table would simplify this procedure.

The treatment of bronchiectasis, as with any other disease, should begin with the removal of the cause. A cure could not be expected while an agent is acting, such as sinusitis, which could produce the disease anew. Therefore, the first step in treatment should be the eradication of the sinusitis.

Many workers have reported benefit and cure from the instillation of iodized oil. Our experience has warranted similar conclusions. No patient has complained of discomfort, and many have felt improved after diagnostic injections, and the therapeutic fillings have uniformly resulted in lessening of the cough and expectoration.

Some question has arisen about using iodized oil

in suspected tuberculosis, the fear being that the congestive action of the iodine might spread the tuberculosis. In the Hudson County Tuberculosis Sanatorium at Laurel Hill iodized oil is used in the x-ray study of frank tuberculosis without any instance of dissemination of the disease.

The surgical treatment of advanced bronchiectasis at times offers the most hope of permanent improvement. Under this head come lobectomy, pneumothorax, phrenicectomy, and thoracoplasty.

Postural drainage is the most direct method of relieving the lung of its purulent burden and should be employed an hour or two before all iodized oil injections. It should also be used once or twice a day to prevent stagnation of the secretions. The patient may lie across the bed with his head near the floor, or may kneel on a chair with his hands on the floor.

LATERAL SINUS THROMBOPHLEBITIS WITH COMPLICATIONS CASE REPORT

By L. FERENCZI, M.D., Bayonne, N. J.

An abstract, presented at the meeting of the Hudson County Medical Society, January 2, 1934.

Dr. Ferenczi presented the history of the following case:

P. R., age 13, male, white, admitted to Bayonne Hospital March 23, 1933, and discharged July 22, 1933, as cured.

High points in his history: Well up to May 9, 1933.

May 9. Pain in right ear, followed by fever and vomiting, all gradually subsiding.

May 14. Recurrence of symptoms.

May 18. Pus began to flow from right ear.

May 20. Pains moderately severe in the hands, wrists, shoulders, and hips. Fever was present.

May 23. On admission to the hospital:

Right ear discharge thick and purulent. Left ear negative. Pharynx injected and tonsils enlarged. Heart sounds were regular; pulse rate 110; blood pressure 120/70. Lungs and abdomen negative. Right hand tender, red and swollen. There was no mastoid or jugular tenderness, and no disturbance of the jugular vein was felt. The temperature varied from 99 to 105° F.

May 25. A blood culture showed 82 colonies of streptococcus hemolyticus to each cc. of blood.

May 26. X-ray of the right mastoid showed clouding, and a destruction of the right mastoid cells.

May 27. A simple mastoidectomy and excision of the jugular vein was done by Dr. Ernest Thum. The blood examination then showed hemoglobin 65%, red cells 2,900,000, and white cells 16,000, with 87% polynuclears, 10% lymphocytes, and 3% mononuclears.

The report on the excised thrombotic vein showed the lumen filled with a thrombus containing a number of polymorphonuclear leucocytes. There was endothelial proliferation, and the entire wall of the vein and the perivascular tissue was in-

filtrated with histiocytes, round cells, and polymorphonuclear leucocytes.

Pain persisted in all the joints for a week, but gradually subsided. The temperature remained of the septic type for a month after operation and then gradually returned to normal.

June 8. The patient started to cough, and his right lung showed dullness from the apex to the third rib.

June 10. X-ray suggested an encapsulated exudate in the right lobe.

June 14. A transfusion of 300 cc. of citrated blood was given because of the secondary anemia and the septic temperature.

June 15. The patient coughed up about a cupful of purulo-hemorrhagic material. The expectoration continued for some days.

July 16. The x-ray examination showed that the area of absent illumination found on June 10, had disappeared. A sputum examination revealed no acid-fast bacilli; but numerous pus cells were present.

Recovery was rapid and progressive, and the patient was discharged July 22, 1933. He had gained about eleven pounds while in the hospital. The boy now attends school regularly and is in good health.

Discussion by Dr. Thum: The findings at the examination before the operation were slight, but the x-ray revealed a serious pathology. The mastoid cells were infected and filled with granulations. The covering of the lateral sinus was necrotic, and the sinus was collapsed and filled with a grayish, fibrinous clot, which also filled the entire jugular vein down to the sternal notch.

The amazing feature of the case was the mildness of the symptoms associated with the great amount of pathology.

State Society Activities

REPRESENTATION AT THE ANNUAL MEETING

The following important communication from the Secretary of the Medical Society of New Jersey is printed for the information of the delegates and executive officers of the component societies.

A few words of explanation are necessary in reference to your representation by delegates in the House of Delegates of the Medical Society of New Jersey.

Your attention is called to Article IV of the Constitution, which provides:

"Each component society shall be entitled to 1 delegate for every 15 members or major fraction thereof, to be elected at its annual meeting by a majority vote of those present, but each component society shall be entitled to at least 3 delegates. Each component society, at its annual meeting following the adoption of this constitution, shall elect its delegates in three groups for 1, 2, and 3 years respectively; and thereafter shall elect its delegates for a period of three years each."

Chapter 1, Sec. 2, sub-section (d) of the by-laws provides:

"The official list as printed each year shall be prima facie evidence of the right of members to register at the annual meeting, and unless otherwise provided for by the House of Delegates, shall form the basis of representation of each component society."

This sub-section was amended in 1932 as follows (see Transactions of the 1932 session of the House of Delegates, page 6, first column):

"Sec. 2, (d) page 13, replace the period at the end of the sub-section with a semicolon, and add 'except that after the official list is printed, and component society which finds that it is entitled to additional

delegates may elect these at its April or May meeting.'"

This, in effect, allows the paid-up membership to form the basis of representation. The names of all delegates and alternates will be published in the official list and in the program of the Annual Meeting; but the Committee on Credentials will recognize all delegates or alternates elected at these April or May meetings.

It should also be noted that, if the membership is less than it was last year, the representation will be correspondingly reduced; and unless otherwise notified by the secretary of the component society, the secretary of the State society will make the necessary reduction by removing the names from the end of the list submitted.

Your attention is also called to Chapter V, Sec. 1, of the by-laws, which reads:

"All delegates shall present to the Committee on Credentials a certificate bearing the seal of the Society and the signature of the Secretary. No delegate will be permitted to register or sit as a member of the House of Delegates without such certificate, nor if the component society of which he is a member has not paid its annual assessment."

The name of the member of the Nominating Committee of the State Society should be in the hands of the Secretary by the first of February, as, according to the by-laws, this list must be published in the March issue of the Journal. Please remember that only the elected delegate or his elected alternate may represent your component society in the Nominating Committee. It is the responsibility of your society to elect only those members or alternates who will attend.

J. B. MORRISON, M.D.,
Secretary.

CURRENT LEGISLATION

Two types of legislation are recognized:

- (a) Constructive Legislation.
- (b) Defensive Legislation.

In the first category are the following bills: A-132 and S-251 aim to free existing legislation of provisions which debar those private physicians who provide services in schools and

other governmental agencies in accordance with legislative enactments from accepting agreed-upon fees for services rendered to indigent patients authorized by the Emergency Relief Administration.

The first mentioned act (A-132) is now a law but the act so amended has been replaced

by a new law (S-42) which contains a similar disbarment provision and it is necessary to secure the passage of a new bill (S-251) to permit fees to be paid to these physicians.

S-136 aims to provide a physicians' lien as an amendment to the existing hospital lien act. This bill is in committee and we believe that it can be passed at the present session if and when the bill is reported out for vote.

Your officers and committee members have been, and are still working to secure the passage of this bill, and believe that it has a good chance of success.

S-183, the doctors' title bill, has met with much opposition by the cultists. This opposition has had the effect of distracting the cultists from a united support of their *own* bills, and in this way has proven to be a good defensive measure even if it is not enacted into law at the session of the Legislature. (See page 187.)

A-4-5-6, to control tuberculosis in school teachers and pupils. These bills provide for examinations by physicians and permit removal of clothing to the waist under proper safeguards to both patient and examiner.

A-4 and 6 have passed the Assembly, and A-5 is held for amendment in committee. There is some opposition in the Senate to these bills and additional pressure will need be brought on Senators to win the necessary support for their passage.

A-256 governs payment of fees of physicians in cases of drunken automobile drivers and will be voted upon at its next appearance in the Assembly. This bill needs support, and is endorsed by the Society.

A-373 authorizes the State Health Department to buy and distribute anti-diphtheric sera and smallpox vaccine to physicians (for use in the "Public Health Hour"), and provides for an emergency appropriation of \$10,000 to carry on this work to July 1, 1934, and makes provision for this item in future budgets of the State Department of Health.

N. B.—This evidence of coöperation on the part of the health executives of New Jersey should elicit on the part of the medical profession a convincing response to this effort to demonstrate the economy and effectiveness of voluntary coöperation with the organized medical profession of the state, and will show the lack of argument for state ownership and control *where the medical practitioners actually carry on the work and provide the necessary records to account properly for the public moneys used.*

In the category of *defensive* legislation we have the following bills:

S-73—which seeks to broaden the scope of practice of the osteopaths who are now practicing, through a retroactive clause which exempts them from meeting the new requirements to be recognized in 1940. By the establishment of higher qualifications in 1940 and thereafter, the present osteopaths will curtail competition against themselves, while they enjoy practically all the rights and prerogatives of regularly licensed physicians and surgeons. The bill is adroitly worded, but the persistent efforts of the members of the Legislative Committees of the County Medical Societies, through their well chosen and "key" men in each county, who have been most effective, have kept these bills successfully buried in committee so far.

S-186, if passed, would have defeated the purpose of A-313 to exempt the Professional Boards from the obligation to turn into the State Treasury funds collected from their professionals. Reallocation of funds to these same boards is believed unnecessary and likely to involve political favor.

S-207 is a unique cult bill aimed to permit the return to the preceptorial plan of medical training for favored cases. If this bill should pass, hundreds of our registered nurses could easily qualify, though in justice to them it is only fair to state that they are not responsible in any way for the introduction of this bill, and have far too much sense and discretion to presume upon the manifestly dangerous provisions offered in this piece of bizarre legislation.

A-303 seeks to provide separate examining boards for osteopaths, chiropractors and naturopaths, and has been successfully combatted so far and held in committee.

A-332 is a chiropody bill which endeavors to exalt a trade to the status of a profession, in competition especially with orthopedists and other physicians who already provide far more effective service in fields which this bill seeks to open to chiropodists without adequate education and training. It is opposed by the Medical Society and appears likely to remain in committee as a result of the efforts of your officers and the Legislative Committee members.

Only the most illustrative bills have been here presented.

In the "Legislative Bulletins" issued periodically from the executive offices, an endeavor has been made to call to the attention of the officers of each County Medical Society, and through them of the individual members, those bills of interest to the profession, and to indicate the Society's attitude on each bill. To include in the Bulletin, without adequate dis-

tion, too many bills tends to confuse rather than aid. The changing status of important bills is indicated to some extent in the Bulletin, but the telephone and the telegraph have served the major purpose of enlisting support of those bills under immediate consideration. The legislative plan in use this year has functioned well, and with improvements already suggested the plan will serve for the future. No work can be satisfactorily planned, and no plan can be satisfactorily "worked", without the coöperation of those selected to serve the Society.

This opportunity is taken to acknowledge the fine work done by the officers and committee members in the State and Component Societies.

President Quigley has given much effort and time to legislation, and his knowledge and experience have contributed conspicuously to the efforts made in behalf of the medical profession of this state.

LE ROY A. WILKES,
Executive Secretary.

CHANGES SEEM INEVITABLE

Certain changes in the procedure of furnishing medical service in the community seem to be inevitable, and may prove to be beneficial.

Changes in the professional practice of medicine as it relates to the individual are quite distinct from the foregoing.

Changes in professional procedure in the sick room and in the therapeutic armamentarium of the doctor have been frequent, and are usually the direct result of research and experience.

Conditions under which we live and work change at frequent intervals, because life itself is dynamic activity.

Preparedness is the process of being made ready to meet changing needs and conditions, and is the outcome of efficient leadership. The effective leader must have imagination and the foresight to anticipate possible changes so as to provide well in advance for defense or attack.

Are we, as physicians, *prepared* for the unforeseen outcomes of these changing times? Are we prepared individually? Are we *organized* effectively for service and for defense? Is this organization local, statewide or national? Have we a carefully planned program and have our moves been scheduled and rehearsed so they may accomplish our aims?

Individual effort becomes less and less efficient as compared with organized effort. This is evident in industry, in agriculture, in government and even in certain scientific procedures.

In medical practice the hospitals, the health departments of states and cities, and the schools are showing the increasing trend toward *organized effort*. The appreciation and demand of the public for such effort is seen on every hand.

Most of us, as physicians, devote ourselves to *service*; and the better organized that service, in the office, in the community, in the

state, and in the nation, the more productive and effective such service becomes.

The physician is the health leader, but others also make health contributions which must be recognized, and coördinated and utilized as supplementary efforts to those of the physician.

Many sincere persons have joined enthusiastically in the promotion of unsound ideas for lack of medical leadership. A most desirable change has come into the perspective of the physician who not long ago was mildly amused at these misguided people, while he failed to interpret their aims and desires. The physician now begins to appreciate that these persons are serious and sincere, and that if he will not furnish guidance and leadership, they will look elsewhere—often to far less competent and experienced leaders, and too often such leaders wilfully exploit these persons who are easy victims because of their sincerity—and in some measure because the physician has not taken their demand for health leadership and instruction as seriously as he should.

We shall see many changes in thought and action in many fields. Inevitably these changes must and will effect the practice of medicine. Perhaps we shall need fewer practitioners—perhaps not. Until a period of reflection is permitted, we cannot build soundly for the future. The practice of medicine has certain aspects which we believe will remain unchanged. Free choice of physician and the intimate relationship which exists between a faithful family physician and those to whose needs he ministers seem to be among those things which should persist. The public changes, it is true, and we, as physicians, change too—for are we also not a part of the public?

LE ROY A. WILKES, M.D.,
Executive Secretary.

County Society Reports

ATLANTIC COUNTY

Robert A. Kilduffe, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held on Friday, March 9, 1934, at Haddon Hall. Fifty-five members and guests were present, and the President, Dr. D. B. Allman, presided.

The Treasurer reported that approximately only 60 per cent of the members had so far paid their dues. Dr. Allman urged prompt payment on the part of the remaining 40 per cent as the society must be kept financially able to carry on its work, and it is only from the payment of dues by the members that this can be possible.

Drs. M. M. Major and Alan Rieck were elected to active membership, and Dr. C. Ferg Phillips, D.D.S., to associate membership. Dr. L. M. Rodi, of Hammonton, N. J., was proposed for membership.

E. R. A. Methods—Dr. J. S. Irvin, reporting for the Medical Advisory Committee, stated that on account of complaints of favoritism, a notice of a change in method of assigning E. R. A. patients to the doctors had been announced. The authorizations for medical treatment will contain no physician's name. Instead, the patient will be given a copy of the list of approved physicians and told to go to any one on the list.

The work in the Atlantic City Hospital Dispensary has increased greatly in the last three years because of economic conditions. Under a new agreement with the E. R. A., these patients are to be cared for by the doctor again. The Dispensary will render first aid treatment to all E. R. A. clients, and will then refer them to the E. R. A., who will in turn refer them to the doctors' offices for further treatment. According to figures available, about fifteen patients per day, will be referred to the physicians.

Graduate Education—Dr. W. J. Carrington stated that thirty-eight members from Cape May, Ocean, and Atlantic Counties were taking the Post-Graduate Course of lectures given by Dr. E. A. Spiegel; and that the course was still open if any other members wished to enroll, as only two lectures have been given. Dr. Carrington said he believed it to be the best course given so far.

Dr. W. P. Conaway reported for the Broadcasting Committee that three broadcasts had been made, and that they would continue on each Friday at 5 o'clock throughout April.

The Lien Law—Dr. H. I. Silvers, discussing the Hospital Lien Law, said: "About two years ago the Legislature passed a law providing for the rendering of bills to patients who had been injured in accidents and who had afterward entered suit and received some remuneration. Originally this bill included the physicians but was later amended to cover only the hospitals.

"Recently the physicians on the staff of the Atlantic City Hospital formulated a plan of action and a schedule of fees running parallel to the charges for compensation cases.

"This has been taken up by the State Society as

concerns the physicians at large, and the proposal that each county society adopt a schedule of fees is now before the State Legislature as an amendment to the present lien law.

"In the opinion of the members of the Committee of the Legislature, to which the bill is referred, one of the stumbling blocks is what they consider a lack of uniformity in charges. It would seem well for this society to go on record as approving the fees charged in these cases by the staff of the Atlantic City Hospital, in order that this objection may be removed."

On motion the fee schedule of the Medical Staff of the Atlantic City Hospital was adopted and the Secretary was instructed to send Senator Richards a telegram to that effect, at the same time requesting his support of the bill.

Dr. D. W. Scanlon stated that there were two bills also before the Legislature at this time which the society should do all in its power to have killed. One is A-303, which would give osteopaths a license to practice medicine and surgery, and A-332, which would give chiroprodists the right to diagnose and treat all ailments of the foot. Dr. Scanlon asked the members to call Assemblyman Siracusa and urge him to vote against these two bills.

It was suggested by Dr. Scanlon that the Medical, Dental and Pharmaceutical Societies have a dinner in the latter part of April and invite the legislators of this county. The suggestion was referred to the Entertainment Committee with the power to act in conjunction with the other societies.

Scientific Session—The scientific paper of the evening was presented by Dr. John J. Moorhead, Professor of Surgery, New York Post-Graduate Medical School, Columbia University, Visiting Surgeon, New York Post-Graduate Medical School and Hospital, Surgical Director, Reconstruction Hospital, New York, whose subject was "Essentials of Traumatic Surgery". Dr. Moorhead presented a succinct yet comprehensive survey of traumatology as it relates to wounds, burns, fractures, sprains, and synovitis.

(An abstract of this paper will be published in a later issue of this Journal.—The Editor.)

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held March 13 at the Hackensack Hospital and was called to order by Dr. A. Liva, President.

Dr. Friedman asked what the \$13 sent to the State Medical Society was for. He was referred to the Journal of the State Medical Society and to the Bulletin of the Bergen County Medical Society.

Communications were as follows:

A letter from Dr. Frederic Qulgey, Chairman of the State Welfare Committee, in which he enclosed legal advice in regard to the increase in electricity rates.

A letter from Dr. L. Wilkes asking our Welfare Committee to set up an organization composed of representatives of the Medical and Dental Professions and the Pharmaceutical Society, for the purpose of presenting a united effort in attempting to obtain the passage of bills safeguarding the public and the professions involved.

Legislative Bulletins No. III. and IV., and an analysis of S-183 (The Doctors' Title Bill).

Replies were received from all our Assemblymen in response to the secretary's letters to them regarding S-73, (The Osteopath Bill), and S-43, (The Emergency Relief Act Amendment).

A letter from the State Department of Health requesting that we allow a space on one of our programs for Dr. A. J. Casselman of the Venereal Disease Department.

A letter from the Parent-Teacher's Association announcing a preparatory meeting for the "Summer Round-up".

A communication from the Woman's Auxiliary of the Bergen County Medical Society stating that money was available for a member of some doctor's family.

A letter to Dr. Corn from Rutgers University in regard to the deficit from the post graduate course. Dr. Hallett moved that the County Society make up this deficit. Motion passed.

The following, Dr. Louis M. Sosnow, Hillside, and Dr. V. L. Hawes, Ramsey, were elected to regular membership.

Dr. Frank Overton, the newly-appointed Editor of the Journal of the State Medical Society, was present, and when asked to talk urged that the County Society send information to the Journal regularly.

Mr. F. E. Whitehead, executive secretary, preparing for a membership drive, read off a list of the non-members. Mr. Whitehead announced that all the public health hour cards were not returned.

The Secretary, as chairman of the Public Health Committee, announced that the diphtheria immunization campaign was getting under way, and asked that the cooperating physicians be prepared to give the immunizations.

Dr. S. Alexander moved that the Society go on record opposing the bill to regulate chiropody which would allow a chiropodist to do practically any kind of work on the feet and a bill, the purpose of which was to create a new Examining Board for osteopaths, chiropractors, and naturopaths. This was seconded by Dr. P. Liva, and passed unanimously.

Dr. S. T. Snedecor stated that an amendment to the Emergency Relief Act had passed the Senate and Assembly, and after being signed by Governor Moore it would permit school physicians and others to receive pay for Emergency Relief Work.

Dr. Charles Littwin reported that Dr. Bernard Sachs, President New York Academy of Medicine would be the principal speaker at our next meeting.

The Scientific Program was in charge of Dr. W. L. James who introduced Doctors S. T. Snedecor and R. Tether who spoke on "clinics". Dr. Snedecor suggested that the Medical Profession should not try to abolish clinics altogether and that they serve four legitimate purposes:

- (1) The care of the emergency sick, or injured.
- (2) A diagnostic clinic.
- (3) A special treatment clinic.
- (4) A follow-up clinic.

Both Dr. Snedecor and Dr. Tether recommended that a real investigation service be established to check up on the inability of clinic patients to pay. It was pointed out that this service should be entirely separated from the social service work.

Dr. Stanley Wang, Chief of Clinic, Tuberculosis Division, Brady Foundation, New York Hospital, spoke on *Urinary Tuberculosis*. He showed many x-ray plates to demonstrate advanced renal tuberculous lesions, unilateral and bilateral, in people who appeared to be in fairly good health.

The paper was discussed by Drs. Joseph Morrow, Trignin, and James.

The meeting adjourned for refreshments.

BURLINGTON COUNTY

H. P. Shipps, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held at the Burlington County Insane Hospital at New Lisbon, N. J. As the guests of the Board of Freeholders, the members of the society inspected the institution so as to become better acquainted with what the county is doing for the insane. The physicians were very favorably impressed with the institution and its management.

Dr. R. I. Downs, Chairman of Section on Surgery, presented the following program: "Traumatic Rupture of Normal Kidney—Diagnosis and Treatment", by Lloyd B. Green, M.D., F.A.C.S., of Philadelphia; "Rupture of Spleen—Diagnosis and Treatment", by F. William Shafer, M.D., F.A.C.S., of Camden.

These papers were presented in a very interesting and enlightening manner and received many favorable comments from those present. They will be forwarded to the Journal for publication at a later date.

During the business session there was free discussion of the medical problems involved in the E. R. A. and C. W. A. Dr. J. M. Kuder, Chairman of the E. R. A. committee, presented the recent developments and regulations in these matters.

Dr. Marcus Newcomb presented a discussion of pending legislation affecting medical practice.

After the session, we were served with a delightful dinner at the home of Mr. Frank McIlvaine, Superintendent of the hospital.

CAMDEN COUNTY

Vincent Del Duca, M.D., Reporter

The February meeting of the Camden County Medical Society was held at the Camden City Dispensary Building, February 6, 1934, at 9 p. m., Dr. T. B. Lee presiding.

Applications for membership of the following men were read for the first time: Drs. Howard E. Primas, 772 Pine Street, Camden, N. J.; Marcus F. Wheatland, Jr., 727 Walnut Street, Camden, N. J., and P. H. Thompson, 4612 Westfield Avenue, Camden, N. J. It was ordered they take the usual course.

The scientific program was made up of case reports. The following case reports were presented and discussed:

(1) "Malignant Edema (Anthrax) Involving the Eye." By A. S. Ross, M.D., and J. S. Shipman, M.D. The differential diagnosis and treatment accorded this case was discussed by Dr. Shipman. There was further discussion by Drs. Lovett, Buzby and Caselman.

(2) "Selective Cases of Collapse of Lung for Treatment of Tuberculosis." By Dr. Thomas McGlade at the request of Dr. M. Collier. Dr. Collier discussed this case, which illustrated the possibility of collapsing the upper lobe in selected cases of tuberculosis without collapsing the lower lobe of the same side. Dr. Hyman I. Goldstein also discussed this presentation.

(3) "Malignant Degeneration of Naevus." By H. E. Wiant, M.D. This case showed the stage of metastasis of a melanotic mole which had undergone malignant changes. A microphotographic slide illustrated the pathology.

(4) "A Case of Banti's Disease" was presented by Dr. H. Eynon. The pathology was discussed by Dr. Grant O. Favorite and further discussion was carried on by Drs. Day and Goldstein.

(5) "Cyanotic Congenital Heart Disease in an Adult", by H. I. Goldstein, M.D. This case was discussed by Drs. J. D. Smith, Shope, Mengel and Shipman.

(6) "Volvulus in the New-Born", by A. G. Kinney, M.D. Pathological specimen was shown and discussion was opened by Dr. Vincent Del Duca, followed by Drs. Ross and Ciliberti.

(7) "Sudden Post-Partum Death, as a Result of Pulmonary Embolism from Thrombus of the Right Ovarian Vein", by Dr. L. L. Glover. Drs. George B. German and A. B. Davis discussed the etiology and infrequency of occurrence.

Dr. Marcus W. Newcomb, of Browns Mills, N. J., Vice-President of the State Medical Society, was introduced and spoke on the legislation now before the State Legislature. He enumerated some of the difficulties presented in introducing and passing bills which safeguard the medical profession and its community from a health standpoint.

Dr. T. K. Lewis gave a report from the Medical Advisory Committee, which is coöperating with the administration of the Emergency Relief. He informed the Society of the impending regulations which requires that each physician submit to this committee the list of cases and diagnosis treated during the month for the E. R. A. He also discussed the relationship of the C. W. A. and the care of its injured.

CAPE MAY COUNTY

Eugene Way, M.D., Reporter

A special meeting of the *Cape May County Medical Society* was held on Friday, February 23, 1934, at 1 P. M. at the Hotel Bellevue, Cape May Court House, N. J. A delegation from all the counties in the Fifth District were also present by invitation of Dr. Aldrich C. Crowe, Councilor of the District.

Dr. Warren D. Robbins presided and introduced

Dr. Le Roy A. Wilkes, Executive Secretary of the State Medical Society, who gave a pleasing address on "Medical Economics including E. R. A., C. W. A., M. A. C., E. C. C., and other alphabetical agglutinations".

Dr. Wilkes outlined the bills before the Legislature and told of the unceasing efforts of the State Society to prevent the passage of many introduced by the various "cults", to give them all the rights of physicians. He dwelt at length on the various "Emergency Relief Plans", and stated that there was now a bill before the Legislature to correct some of the discriminations against physicians. Discussion was entered into by Mr. Bowen of the State Board of Health, Drs. Dandois, Knight, Monasson, Friedland, Davis, Crowe, White, Corson and others.

The meeting was full of "pep" and very interesting. While no problems were solved, we can only hope that something may have been started that will bring desirable results. Dr. Robbins stated that it would be well to increase the activities of the County Committee on Welfare, Public Health and Legislation, and appointed Drs. Crowe and Ziegler as additional members. The committee now consists of Drs. J. Way, Robbins, Cryder, Crowe and Ziegler.

President Robbins then called on Dr. C. W. Way, for a report on the Annual Post-Graduate Course. Dr. Way reported that the course will be given at the Atlantic City Hospital in conjunction with Atlantic County by Dr. E. A. Spiegel of Temple University; and will consist of a series of six lectures on "Clinical Interpretations of Neurological Symptoms", beginning February 28 and ending April 4, 1934. The fee for the course is \$10.00.

Registration blanks were subsequently signed by Drs. Corson, Darby, Whitacar, Pettit, Townsend, Tomlin and C. W. Way.

ESSEX COUNTY

Earl Le Roy Wood, M.D., Reporter

The President of the American Medical Association, Dr. Dean Lewis, addressed the *Essex County Medical Society* Thursday evening, March 8, at the Academy of Medicine, Newark.

Dr. Lewis took for the title of his paper "The Old and the New" in which he directed attention to several new factors in the practice of medicine comparing them with the past experience. The new factors to which Dr. Lewis referred were the various councils and foundations which control funds of investigators, and draw conclusions which are contrary to the experience of practicing physicians. The new organizations are functioning by means of an elaborate system of buildings, equipment, supervisors, publicity agents, and all the other paraphernalia of a highly complicated business system in which the individual moves with the other parts of the machine. Dr. Lewis urged the retention of the old system of the practice of medicine by individual doctors. After all, even the most highly developed system of medical organization must necessarily make the actual production and delivery of its service by the exactly same method that our grandfathers followed, which is the con-

tact of the individual doctor with the individual patient. All the elaborate machinery exists for the purpose of bringing a doctor to a sick person for the specific purpose of examining and treating that person. The whole complicated system of the newer dispensation is dependent in the last analysis upon the individual physician, who is best exemplified by the skillful family doctor.

A business meeting followed Dr. Lewis' paper, the President, Dr. Edward W. Sprague, presiding, and Dr. Pinneo reading the minutes of the previous meeting.

The following recommendation was endorsed:

"At this time it seems proper and fitting that the *Medical Commission for Maternal Welfare of Essex County, New Jersey*, recommend certain procedures for the consideration and approval of the Council of the Essex County Medical Society, with the request that the same be presented as a resolution before the members of the Essex County Medical Society at its next regular meeting. It is felt that this will be a very important step forward in the continued improvement of obstetrics in Essex County.

"This Commission has conducted a six years' survey of the obstetrical work and statistics in sixteen hospitals in Essex County. In these hospitals as a group during these years it was found that 10 per cent of maternal deaths followed cesarean sections, and that a large percentage of the other maternal deaths occurred after obstetrical operations.

"In conformity with the ideals of the American College of Surgeons, it is strongly recommended that in every major operative obstetrical procedure, and in every abnormal or prolonged labor, supervision or consultation must be had; that this may be given by any qualified consultant. It is assumed that this matter will be handled with the utmost tact and consideration for the patient concerned, for her family, and for her physician. It is further taken for granted that the question of any fee for consultation be entirely a secondary matter, and be waived absolutely whenever desirable, as has been done heretofore in many cases."

Dr. Henry Barkhorn reporting for the Committee on Emergency Relief Administration, stated that all doctors who desire to treat residents of Newark under the E. R. A. plan must register at 43 Washington Street, Newark.

Dr. Frederic Quigley, President of the State Society spoke on the status of proposed legislation which is of interest and concern to the doctor.

Dr. Edgar Ill, reporting for the Public Health Committee, urged all physicians to register for the diphtheria immunization work. To promote and simplify this work he had met with the health officers of Essex County.

The following new members were elected:

Regular—Jacob L. Flax, 250 Hawthorne Avenue, Newark; Meyer Nimaroff, 265 Union Avenue, Irvington; Jerome H. Samuel, 299 Clinton Avenue, Newark.

Associate—Anthony P. Caggiano, 135 Grove Street, Montclair; Max Cohen, 732 Lyons Avenue, Irvington; John Robert Gilmour, 75 Prospect Street, East Orange; Walter P. Merkelbach, 402 Bloom-

field Avenue, Caldwell; Harry W. Mickey, 23 Laurel Avenue, Maplewood; F. Harry Schurman, 15 Arlington Avenue, Caldwell.

Maternal Welfare

Carl H. Ill, M.D., Secretary

On January 18, 1934, there was held a joint meeting of the *Academy of Medicine of Northern New Jersey* and the Maternal Welfare Committee of the State Medical Society with the members of the Maternal Welfare Commissions of the various counties. The meeting was called to order at 5.30 P. M., by the chairman who spoke briefly on the problems connected with maternal welfare work. Reports were then given by members representing the different counties.

Thirteen counties were represented by thirty members: Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Hudson, Mercer, Monmouth, Ocean, Passaic, Somerset and Union. This representation showing such wide coöperation is very much appreciated by the committee. There were also present a number of guests including some of the health officers as well as Dr. Edward A. Schumann of Philadelphia.

Dr. Mount read a resolution that the Essex County Maternal Welfare Commission has offered to the Council of the County Society recommending consultation in prolonged labors and abnormal obstetrical cases.

While maternal welfare work in some counties is better organized than in others, the reports indicated great interest. Members of the State Committee have been invited to meet with County Societies to discuss features of maternal welfare activities as carried out in different counties.

The discussion was followed by a dinner given by the Maternal Welfare Commission of Essex County, which was enjoyed by all. The meeting then adjourned to the Academy of Medicine and Dr. Schumann gave a talk on "Leaves from an Obstetrician's Note Book". This paper was interesting and instructive, and was discussed by many of the doctors.

The next maternal welfare meeting will be at Atlantic City on June 6, at 4 P. M., when Dr. Robert L. DeNormandie of Boston will be the speaker, and there will be reports from the various counties.

The Academy of Medicine of Northern New Jersey Section of Medicine and Pediatrics

Benjamin Saslow, M.D., Secretary

The 170th monthly meeting of the *Section of Medicine and Pediatrics* was held at the Academy of Medicine on February 13.

Dr. J. Polevski, chairman of the section, introduced the speaker, Dr. Charles E. Teeter, of Newark. His subject was: "*Fever of Obscure Origin*".

Dr. Teeter opened his talk with a perfunctory consideration of the large group of cases of obscure fever which, even after exhaustive laboratory and clinical study, yield no clue as to their origin. Many of these cases get well without diagnosis or treatment.

Next, Dr. Teeter considered his experience with many of these so-called obscure fevers from an etiologic and diagnostic standpoint.

Obscure fever may have as its cause, subacute bacterial endocarditis. This diagnosis may be very difficult to make without a positive blood culture and other classical accompanying symptoms and signs.

A portal thrombophlebitis may result from any pyogenic infection in the abdomen or rectum, and in such cases, a confusing septic temperature without physical signs referable to the liver, may obtain. The blood culture will be negative, since the liver acts as a barrier to the secondary portal thrombophlebitis.

Fever of obscure origin is found frequently in the cryptic variety of Hodgkin's disease.

Acute diffuse generalized miliary tuberculosis may give a septic temperature and is often mistaken for typhoid fever. The retinal tubercles is an unusual finding, and the diagnosis is most often made on the autopsy table.

A remittent type of fever is found in cases of internal malignancy, and its cause, excluding secondary infection, is not clearly understood.

Trichina spiralis infections will give bouts of septic temperature; and a muscular section and the characteristic eosinophilia, will make the diagnosis.

Brucella abortus infections from drinking the milk of infected cows, have been seen twice by Dr. Teeter.

Other causes of obscure temperature mentioned by the speaker were (a) Vincent's angina, (b) infections around teeth, (c) chest infections, and (d) bed-sores.

Dr. Teeter illustrated the above mentioned diseases with many cases.

Next, Dr. W. W. Wolfe, of Newark, presented a case of Gliosis Springo-myelia, which was discussed by Drs. H. S. Martland and C. C. Beling.

The meeting was closed at 11 P. M.

Eye, Ear, Nose and Throat Section

A. Russell Sherman, M.D., Secretary

A stated meeting of the *Academy of Medicine of Northern New Jersey* was held Thursday, February 15 under the auspices of the Eye, Ear, Nose and Throat Section. The president of the Academy, Dr. Bingham, turned over the meeting to Dr. Browne Morgan, chairman of the section, who announced the appointment of a committee for the purpose of nominating officers for the next year, the members of the committee being L. W. Hughes, chairman, B. E. Failing and S. H. Baldwin.

Dr. Morgan then introduced the speaker of the evening, Dr. Charles H. Frazier, who spoke on trigeminal neuralgia, saying in part as follows:

Major trigeminal neuralgia is a condition in which all symptoms are subjective, but the syndrome is usually so typical that the diagnosis should be made comparatively easy in the great majority of cases. Characteristically the disease is first manifested in middle life, is unilateral, and is confined, at least in the beginning to the distribution of one branch of the fifth nerve.

The pain is described as sharp, shooting, cutting, or burning pain, and comes always in momentary attacks—perhaps only two or three times the first year, more frequently the second, until after ten or fifteen years there is more or less pain constantly. It is referred peripherally, to the tip of the nose, to the lips and lid borders, and is commonly brought on by movement of muscles supplied by the fifth nerve or by contact with one of the so-called "trigger zones".

Some atypical features are paroxysms lasting more than a few seconds, greater severity of the pain at night, herpetic eruptions, and visual disturbances. Rarely the distribution may not be confined to the anatomical zones.

The surgical treatment of choice is partial section of the sensory root of the ganglion. Section of the root was first proposed by Speller in 1899, fifteen years after resection of the ganglion itself had been suggested by Mears.

The meeting adjourned at 10.15 P. M. Eighty-five members and guests were present.

The Academy of Medicine of Northern New Jersey

Adrian Ralph Kristeller, D.D.S., Secretary

The Anniversary Meeting of the *Academy of Medicine of Northern New Jersey* was held on March 15, 1934. Dr. Norris W. Vaux, Clinical Professor of Obstetrics at Jefferson Medical College and Chief of Obstetrical Service at the Philadelphia Lying In Hospital, spoke on "Essentials of Maternity Care". His illuminating and interesting talk was enjoyed by the members and their guests. There were some questions asked by various members following this paper.

Dr. Erwin Reissman, Chairman of the Nominating Committee, tendered the following report: Dr. Guy B. Payne for Vice-President for two years, Dr. H. B. Epstein and Dr. F. R. Haussling for Trustees for five years, Dr. Royal M. Schaaf for member of Committee on Admissions for three years and Dr. E. P. Cardwell for member of Committee on Library for three years.

It was announced that Professor John Wyckoff, Dean New York University, Bellevue Medical College, would be the guest at the April meeting under the auspices of the Section of Medicine and Pediatrics of which Jacob Polevski, M.D., is chairman and Benjamin Saslow, M.D., is secretary.

The Associated Physicians of Montclair and Vicinity

Edwin A. Seifert, M.D., Secretary

The regular meeting of the *Associated Physicians of Montclair and Vicinity* was held at the Essex County Isolation Hospital, Belleville, N. J., on Friday, February 23, 1934, at 8.45 P. M.

Dr. Howard Lillenthal of New York City, Attending Surgeon to the Bellevue and Mt. Sinai Hospitals, gave a very interesting paper on "Principles of Drainage in Thoracic Surgery".

He addressed the association on the various types of empyema which he classified as: (1) Peripheral, (2) Mesial, (3) Supraphrenic and (4) Interlobar. He pointed out the various safeguards and errors to consider in the methods of aspiration and drainage.

age of these pathological conditions. This was followed by a discussion on mediastinitis and pericarditis and the surgical treatment for each. The various methods of technic were appreciably accentuated by accompanying diagrams and illustrations which were projected on the screen.

Light refreshments were served at the close of the meeting.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The *Gloucester County Medical Society* met on the evening of March 15 at the Hotel Pitman, in the Village of Pitman, with twenty-two members and six guests present. The Auxiliary also met.

Delegates attending the meeting from the Cumberland County Society were Drs. Wilson and Woodruff, and from the Camden County Society Dr. Emma Richardson, Dr. Oram Kline and Dr. Joseph Stein.

Reports presented by Dr. I. W. Knight, for the Public Health Committee, and Dr. Henry L. Sinexon, for the Emergency Relief Committee, were discussed at considerable length.

Dr. Thomas M. McMillan, of the Graduate School of Medicine, University of Pennsylvania, gave an interesting talk on "Rheumatic Heart Disease", which was illustrated with slides.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held at the Carteret Club, Jersey City, on the evening of Tuesday, March 6, 1934, with the Vice-President, Dr. Ellis J. Chapman, in the chair.

The Secretary stated that at the meeting of the Executive Committee on February 19, 1934, a committee of five was appointed by the President to act in an advisory capacity for the Civil Works Administration. This committee consists of Dr. M. A. Pinkerton, Dr. P. Hammer, Dr. George F. Sullivan, Dr. A. J. Bruder and Dr. James G. Enwright.

There was some discussion as to the advisability of carrying out the work of the C. W. A. committee, since it will soon be out of existence. In spite of this fact, however, it was decided to keep on with the C. W. A. work as long as the project remains in existence.

Dr. Maurice Shapiro raised a protest against the dues of \$13 required by the State Society, as against the county society dues of \$5. He felt that the State Society was asking too much in return for which, Dr. Shapiro stated, this society and its members are getting little.

Dr. Perlberg offered the following motion:

"Resolved, that it is the sense of the Hudson County Medical Society that the State dues are too high, and that \$7 maximum for the State dues be recommended, and that this motion be referred to the delegates of this County Society who shall present it to the State Society at the Annual Meeting in October."

This motion was seconded and carried.

Dr. Herman Jaffe moved that the results of the

above motion be sent to the Secretaries of each County Society in the State. Carried.

The Nominating Committee then reported the names of candidates for the various offices and committees in the Society, to be voted upon at the Annual Meeting in October.

Dr. Forman then presented his report of the Anti-diphtheria Committee, stating that the work of this committee is progressing slowly but in the right direction. Dr. Forman was very anxious that this be made a permanent committee and that it continue as a committee of this society until diphtheria is wiped out of Hudson County. The principal difficulty to be first overcome is the lack of funds to carry on the work. The Hudson County Board of Health is behind this movement and is coöperating with the Anti-diphtheria Committee.

Diphtheria prevention should be by the individual doctors rather than by the clinics, and the coöperation of the physician is requested, particularly, in the cases of indigents where treatment is to be given without pay; for the others, the doctor's usual fee is expected.

Dr. Forman requested every physician to report these cases which are inoculated, and efforts are being made to put into the hands of every doctor a postal card on which to make his record, and mail it to the Hudson County Board of Health.

The school authorities are all ready to coöperate, as well as the State Board of Health. A sum of money has been set aside for the work, and a part of that money will be received by this committee for the county work. This committee will recommend to every physician in the county the toxin-antitoxin to be used. It is to be hoped that this material will be furnished to each and every doctor in the county society, and they will be available in the police precincts. Dr. Cosgrove stated that the money requested by the state for this work is not yet available. Dr. Quigley had gone to the State Board of Health and asked its coöperation in obtaining supplies of toxin-antitoxin which private physicians may use for indigents and semi-indigents.

Dr. Pollak requested that it be announced that the second series of lectures given by the Public Health Committee on the Tuberculosis Clinics will be held at the Nurses' Home of the Medical Centre at 4:30 p. m. on March 9. Dr. James B. Amberson, of Bellevue, will lecture, and the title of his subject is "Clinical Forms of Tuberculosis in Children and the Course of the Prognosis and Treatment".

During the scientific session Dr. Joseph F. Londrigan of St. Mary's Hospital, Hoboken, occupied the chair and presented the following speakers from the Staff of the hospital:

Dr. George Ginsburg, on "Do Patients Hold Weight Put On with Insulin?"

Dr. Walter Gonzales, on the "Treatment of Scarlet Fever and Anterior Poliomyelitis".

Dr. George F. Sullivan, on "Surgical Diathermy as a Method of Tonsil Extirpation".

Dr. T. Z. Schück, on "Clinical Observations on Perforated Gastric Ulcer".

Dr. W. J. Mathews, on "Intestinal Evisceration".

It is expected that abstracts of these papers will be published in The Journal.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The *Mercer County Medical Society* met in the Trenton Country Club, March 14, 1934, President John A. Connelly presiding.

Dr. A. J. Casselman, Consultant on Venereal Disease Control in the State Department of Health, delivered a very interesting discourse on the subject of "Venereal Disease Control". He spoke in detail relative to the legislative authority vested in the Department of Health regarding the general supervision of venereal diseases, and requested an earnest coöperation on the part of the medical profession in reporting them. He also brought out practical points in relation to the diagnosis, prevention, treatment and cure of the several conditions coming within the scope of the Department of Health, and answered many questions asked by the members.

Dr. W. R. Little, Chairman of the Post-Graduate Committee, made a verbal report regarding the progress that his committee had made in the preparation for the forthcoming sessions. Dr. J. F. Pessel, a member of the committee, read in detail the outline of the several courses, and presented a most interesting and instructive tentative program, which was well received.

Dr. D. L. Haggerty, Chairman of the Legislative Committee, reported in detail the progress of several important legislative bills, referring to the nature and purport of the many bills affecting the medical profession, finally making the motion that a committee be appointed to formulate a schedule of fees, pending the passage of a bill embodying a physician's lien. This motion was carried and the President appointed a committee consisting of Drs. Sommer, Ackley and McCullough.

Dr. Wilbur Watts presented a verbal report relative to E. R. A. work. De LeRoy A. Wilkes, Executive Secretary of the State Society, spoke with reference to certain employed physicians in their relation to this service.

Referring to the several plans submitted for consideration by collection agencies, Dr. Watts expressed the opinion that, since the society had gone on record as in favor of the plan presented by the Physicians' Branch of the Trenton Credit Association, the other plans should be filed. Dr. Wilkes offered the suggestion that, as the physicians' list for E. R. A. clients remains an open list, the Secretary should forward to the Director of Relief the names of the physicians so expressing themselves, as reported to him.

Dr. B. R. Wayman was elected an active member, and Dr. A. Albert Carabelli an associate member of the society.

A communication from Dr. H. C. Barkhorn, Chairman of the Publication Committee of the State Society, relative to "potential advertisers" was read and ordered filed.

The annual communication relating to delegates to the House of Delegates, from Secretary Morrison, was read and due notice taken.

A communication from Dr. H. J. Perlberg, Secretary of the Hudson County Medical Society, with reference to the \$7 maximum for State dues, was read and ordered filed.

Dr. Wilkes gave a report of a combined meeting of representatives from the Welfare Committee, County Dental Society, and Pharmaceutical Society held recently, for the purpose of enlisting legislative support of all bills of mutual interest, and making an urgent appeal for coöperation on the part of all medical men.

MIDDLESEX COUNTY

George F. Hilker, M.D., Reporter

The regular monthly meeting of the County Society was held Wednesday, February 21, 1934, at Metuchen Inn, Metuchen, New Jersey.

The guest speaker, Dr. John L. Kantor, of New York City, Associate in Medicine, Columbia University and visiting physician at the Vanderbilt Clinic started the evening by giving an extremely enlightening talk on "Serious Diarrhea", discussing the subject from etiology to the treatment.

Letters were read from the following:

The State Board of Pharmacy, containing a list of drugs obtainable by the laity only on prescription.

A report was received from the Post-Graduate Committee: Extension courses will begin this year on March 22, 1934, and continued every week for six weeks. The charge is \$10. The program follows:

First lecture, March 22, 1934, at 4 P. M.—Etiology and specific treatment of Lobar Pneumonia. Dr. A. Kolmer, Professor of Medicine, School of Medicine, Temple University, Philadelphia.

Second lecture, March 29, 1934—Infectious Heart Diseases of Various Types. Dr. Clarence E. De La Chapelle, Associate Professor of Medicine, New York University.

Third lecture, April 5, 1934—Syphilitic Arteriosclerotic Heart Diseases. Dr. Clarence E. De La Chapelle.

Fourth lecture, April 12, 1934—Cancer of Breast, General Considerations, Diagnosis and Differentiations. Dr. John F. Erdman, Professor of Surgery, Columbia University, New York Post-Graduate Medical School.

Fifth lecture, April 19, 1934—Pelvic Surgery. Dr. Frederick C. Holden, Professor of Obstetrics and Gynecology, New York University, New York City.

Sixth lecture, April 26, 1934—Fractured Skull, Management and Sequellae. Dr. Temple Fay, Professor Neurosurgery, School of Medicine, Temple University, Philadelphia, Pa.

Dr. J. J. Mann, Chairman of the Public Health Committee, made a motion that all doctors agreeing to do diphtheria immunization work should have their names published in the newspapers. This motion was voted on and accepted.

The following were elected Associate Members:

Dr. H. C. Goldberg, Perth Amboy.

Dr. Murray C. Jacobsen, Perth Amboy.

Dr. Robert Pinnerman, South Amboy.

Dr. Davidson.

Dr. B. Glasser, New Brunswick.

Dr. V. O. Lesh, South Amboy.

Application of Dr. Joseph Degenhart for Associate Membership was received and referred to the proper committee.

Dr. Wilentz reported on the various aspects of the E. R. A. and C. W. A. and advised the doctors of the various procedures to be followed in different cases. He also stressed the fact that all E. R. A. cases must be reported by the doctors if they wish to be paid.

Upon motion by Dr. London, the County Society went unanimously on record as favoring State Bill No. 132 which now exempts doctors from being barred from E. R. A. cases if they are in State, County or Municipal employ.

A letter was read from Dr. Karl Rothschild outlining the proposed work of the County Department of Mental Hygiene and stating that their aim was to keep as many cases as possible at home to be cared for by their family physician, instead of being sent to an institution.

Dr. Sullivan reported that there are two hospitals in the county who have no medical representation on their Board of Governors. Dr. McKiernan advanced the idea that all hospitals should have medical representation on their governing boards.

Medical Section of Rutgers Club

John H. Rowland, M.D., Secretary

The regular monthly meeting of the *Medical Section of the Rutgers Club* was held at the Woodrow Wilson Hotel, New Brunswick, N. J., on Wednesday evening, February 28, 1934, with the chairman, Dr. B. M. Howley, presiding, and sixteen members and three guests present.

Memorial resolutions were adopted regarding Dr. Frank C. Johnson, whose death was recorded in the February Journal, page 124.

Dr. E. I. Cronk for the Committee of Public Health Relations reported on the absence of epidemics of contagious diseases in New Brunswick, and the general health conditions in the city.

The guest speaker was Dr. Franklin Paine. Dr. Paine divided his talk into (1) the physiology of endocrines of the body as they pertain to the female sex organs; and (2) their clinical application, stressing particularly the treatment of sterility, amenorrhea, dysmenorrhea, and functional bleeding. He also mentioned the advantage of quantitative determination of the pituitary and pituitary-like hormone in the Aschem-Zondek test and the Friedman test for pregnancy, as for example when there is a pronounced increase in the hormone, indicating presence of chorionic epithelioma and hydatiform mole.

The speaker considered that very few of the commercial endocrine products were of clinical value. He stressed the importance of thyroid in some of these abnormalities, as giving the best promise of improvement.

MONMOUTH COUNTY

Samuel Edelson, M.D., Reporter

The monthly meeting of the *Monmouth County Medical Society* was held at the Fitkin Memorial Hospital on February 28, 1934. Dr. J. E. Maher presided. Dr. George S. Stevenson, Middletown,

and Dr. Sidney P. Becker, Keyport, were elected to membership. Applications for membership were received from Dr. Oscar H. Hyer, Matawan, and Dr. M. Arnold Aaronson, Long Branch. The applications were referred to the Board of Censors. A letter from the President of the Monmouth County Dental Society was read. Closer cooperation as regards legislative matters was requested between dentist, pharmacists and medical men.

The meeting was addressed by Dr. Frederick K. Elliott, Brooklyn, N. Y., Chairman of the Committee on Economics of the Medical Society of the State of New York. Dr. Elliott declared that the people who controlled the various phases of investigation of medical problems and the practice of medicine had never practiced medicine. These groups were attacking the problem from a purely sociological viewpoint. He stated that although the practice of medicine was a *profession*, the providing of medical care was a *business*. Medicine should be socialized only when the providing of food, shelter, and clothing were socialized.

Dr. Elliott made a plea for organization in medicine, and stated that organization should be real and not mythical. He believed that certain sums should be set aside to protect the investments of physicians and prevent encroachments from unfair competition. Public health problems and preventive medical problems were discussed from an economic standpoint. The method adopted by the New York Society for dealing with the patients who were temporarily in financial straits was discussed.

SCIENTIFIC SESSION

The meeting was addressed by Drs. I. Sherwood Wright and A. Wilbur Duryee, Post-Graduate Hospital, New York. The subject was "Peripheral Vascular Disease and Capillary Circulation". Dr. Duryee spoke on the diagnosis of peripheral vascular disease; Dr. Wright on the treatment.

Peripheral vascular disease is divided into two main groups, the occlusive type and the spastic type. Both types overlap.

The main conditions discussed as regards diagnosis, prognosis, and treatment were: (a) the occlusive group—(1) Thrombo-angitis obliterans, (2) arterio-sclerosis. (b) The spastic group—(3) Raynaud's disease, (4) erythromelalgia (Greek, *erythros*, red; *melos*, limb; and *algos*, pain).

The following points should be taken into consideration in diagnosis, especially in the borderline cases of thrombo-angitis and arterio-sclerosis—sex, age, race, type of pain, discoloration, ulceration, pulsation of vessels, associated phlebitis, x-ray of vessels, arteriograms, and oscillometric determinations.

The speakers stressed the fact that early changes could be detected by *capillary nail-bed* studies. Photographs of normal and abnormal capillary beds were exhibited. The changes in the arterial and venous loops of the capillaries were demonstrated. According to the essayists, cigarette smoking produces a definite drop in surface temperature. This is produced by blood vascular spasm and consequent slowing of the blood stream.

In the treatment of peripheral vascular disease, the following factors were outlined:

- (1) All aggravating factors should be removed, including foci of infection.
- (2) Attempt to keep from surgery.
- (3) Postural exercises of Buerger.
- (4) At Post-Graduate, no intervenous saline is used.
- (5) Heat—Diathermy.
- (6) Contrast baths.
- (7) Non-specific protein therapy.
- (8) Rest in bed.
- (9) Drugs of the acetyl-choline group.
- (10) Tissue extracts.

A practical demonstration of capillary circulation, using one of the physicians present as a subject, was given.

CLINICAL CONFERENCES

The following program was presented at the clinical conferences of the Fitkin Memorial Hospital, Neptune, N. J., on March 11, 1934:

- (1) Bacteremia in infant one month of age.
- (2) Meningitis following mastoidectomy.
- (3) Trichiniasis.
- (4) Discussion of tumors of left upper quadrant.
- (5) Perforated gastric ulcer, patient 19 years of age.

The following program was presented at the clinical conference of the Monmouth Memorial Hospital, Long Branch, N. J., March 14, 1934:

- (1) Jaundice—differential diagnosis.
- (2) Pelvic infection following delivery.
- (3) Infectious mononucleosis—two cases with positive heterophilic reactions.
- (4) Patient with pernicious anemia, lues, and esophageal diverticulum.
- (5) Dilated and hypertrophied heart in an infant. Discussion of etiology.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A regular quarterly meeting of the *Morris County Medical Society* was held the evening of Thursday, March 15, 1934, at the New Jersey State Hospital at Greystone Park; with the President, Dr. I. F. Frost in the chair, and sixty members present. Dr. Frederic J. Quigley, President of the Medical Society of New Jersey, and Dr. LeRoy A. Wilkes, Executive Secretary, were also present and gave stimulating addresses.

Routine business embraced the reading and approval of the proceedings of the quarterly meeting held in December (Jour., Jan., p. 58), the three intervening special meetings including the clinics conducted by members of the society at Morristown Memorial Hospital (Jour. Feb., p. 120) and Dover General Hospital and one for final action on the plan for the medical care of E. R. A. indigent patients (Jour., March, p. 182). Proceedings of the Executive Committee also were read, including a proposal of the Morris County Tuberculosis Association for a school survey in reference to tuberculosis which they wished to conduct in cooperation with the county society.

New members elected were Dr. George L. Nicoll, of Dover; Dr. Earl DeW. Stage, Morristown; Dr. Marc V. Abrams, Morristown; Dr. William Garland Talmage, Succasunna; and Dr. Clifford Mills, of Morristown.

President Frederic J. Quigley of the State Society and Executive Secretary LeRoy A. Wilkes both addressed the society and described plans under way and in contemplation from the standpoint of legislation, administration, and medical welfare and public health in general, in a manner that was potent for the interests of the medical man. President Quigley prefaced his inspiring address by stating that there is one good thing that has come out of the depression so far as we are concerned and he thought ultimately would redound to our good: that the profession as a whole has arrived at the stage where it feels as a question of right that they should do certain things to improve their condition; that after three years of being buffeted around, it seems the profession is ready to have a policy set up, the main objective of which is to improve our financial status. He did not think that policy is entirely selfish. He outlined a program divided into two phases; first, to do those things that would be of immediate benefit to the profession; and second, to launch a program which will by steady work improve the status of the physician.

Executive Secretary LeRoy A. Wilkes gave a very enlightening talk on public health matters, and on legislation not only in the interests of the profession, but also that opposed to the high aims and ideals of the profession.

A communication was read from Dr. Perlberg, Secretary of the Hudson County Society, containing a proposal that the annual dues to the State Society be reduced to \$7. This communication was considered, and the consensus of the members of the Morris County Society was that they felt they were receiving full value for the annual dues to the State Society and realized that there could be no radical reduction unless the constructive activities of the state officers were to be curtailed; and they did not think in these times and conditions there should be any curtailment or any slowing down of the widespread interest of the profession in attaining the goals that the state officers have so definitely set for attainment and are so ably furthering to accomplishment.

Dr. Pinckney reported for the committee to meet with the committee of the Morris County Tuberculosis Association in reference to their plan for a school survey for tuberculosis, stating that the association planned to survey only one school at present, the Morristown High School. The plan to have this survey made under the advice and cooperation of the Morris County Medical Society was unanimously adopted.

Scientific Session—The guest speaker was Dr. George F. Hoch, Urologist at St. Luke's Hospital and the Woman's Hospital, New York City, who gave a paper on "The Irritable Bladder in the Female". An abstract of this paper will be published in a later issue of this Journal.

After the formal meeting, by invitation of Super-

intendent Curry of the Greystone Park State Hospital, refreshments were served and enjoyed in the cafeteria.

A special meeting of the *Morris County Medical Society* was held the evening of Thursday, March 1, 1934, in the Nurses' Home at the Dover General Hospital. The meeting was one of the series of intra-society clinics that have been planned, wisely so judging from the interest of the members. There were about forty present notwithstanding the uninviting traveling conditions.

The meeting was conducted entirely by the hospital staff and aroused attentive interest and stimulated elucidating discussions on various points.

Dr. C. A. Plume opened the proceedings with "Adolescent Rickets with X-Ray Demonstrations". The discussion was led by Dr. Tidaback, and continued joined by Dr. John K. Adams, Dr. Larson, Dr. Pinckney, Dr. Frost and others. It was brought out that in various conditions "rickets" is a misnomer, and that in this country with the better living standards cases of true rickets have been greatly reduced.

The next subject presented was "Sinus Thrombosis Complicating Mastoiditis" by Dr. Alvan Spencer, who reported on three cases, detailing the symptoms and treatment. He presented two subjects who were treated and progressed to recovery. Discussion on this subject was led by Dr. Mathews.

The subject of "Fracture of the Femur, and its Treatment by the Russell Traction", was presented and demonstrated by Dr. W. F. Costello in interesting detail with the use of traction on a subject. The necessity of much attention, and observation, and of frequent adjustment was stressed. Discussion was led by Dr. Frank H. Pinckney and Dr. Bernard C. McMahon, followed by others and Dr. Costello answered various questions asked.

"Skeletal Traction" was presented by Dr. A. L. Baker with discussion led by Dr. B. G. Sherman.

Dr. John K. Adams of East Orange, Visiting Orthopedic Surgeon to the Dover General Hospital, entered into the various discussions, and gave freely and informatively of his wide experience in his specialty. Doctor Adams also set up and demonstrated an apparatus for quick reduction of compressed fracture of the spine, this being a convenient and simple apparatus that can be carried by the physician in his automobile and put into use anywhere in any circumstances, with adjustment made by use of the automobile jack.

The meeting closed with refreshments.

OCEAN COUNTY

Eugene G. Herbener, M.D., Reporter

The regular winter meeting of the *Ocean County Medical Society* was held on Wednesday evening, February 28, 1934, at Murray's Log Cabin, Lakewood, New Jersey, beginning with a social dinner at 6.30 P. M. The president, Dr. Abraham Goldstein presided, and about twenty members answered the roll call.

The program consisted of a discussion of economic problems in which every physician of Ocean

County is directly interested. Our guest speaker, Dr. LeRoy A. Wilkes, Executive Secretary of the Medical Society of New Jersey, gave us a very interesting synopsis of Senate Bill No. 73, which he urged every member to oppose. This bill would remove the existing restrictions upon osteopaths, and would extend their privileges so that nearly every form of medical practice and surgery would be open to them.

Dr. Wilkes also explained the workings of the New Jersey Emergency Relief and the Civil Works Administrations.

A general discussion followed, and Dr. Wilkes answered many questions which gave us a better understanding concerning both relief measures.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

A combined meeting of the *Passaic County Medical and Dental Societies* was held at the Alexander Hamilton Hotel of Paterson, Thursday evening, March 8. The meeting began with a dinner in honor of Doctor Russell L. Cecil, Professor of Clinical Medicine of Cornell University Medical School, and was attended by twenty-two members of the Medical Society and twenty-five members of the Dental Society.

The meeting was opened by Dr. Harry F. Willard, President of the Passaic County Medical Society, at the request of Dr. Singer, President of the Passaic County Dental Society. A warm welcome was extended to the members of both societies, and the hope expressed that a joint meeting might be held at least once a year. By the consent of both societies all business matters were dispensed with so that all the time might be given to the scientific session.

Dr. G. V. Boyko introduced the guest speaker of the evening, Dr. Russell L. Cecil, who spoke on "Dental Infection and Its Relationship to Systemic Diseases".

Dr. Cecil gave an admirable summary of the relationship between focal infections and systemic diseases, particularly arthritis, endocarditis, neuritis, and septicemia. He stressed the importance of full coöperation between the dental and medical man in the eradicating of infection and preventing needless extraction of good teeth.

The paper was discussed by Doctors Boyko, Haden, Lentz, Wassing, Roemer, and others.

The Passaic Practitioners' Club

Irving Okin, M.D., Secretary

The regular monthly meeting of the *Passaic Practitioners' Club* was held on the evening of Tuesday, March 6, 1934, in the Ritz Ball Room, Passaic, with the President, Dr. A. Kroll, Jr., in the chair and about fifty members present.

The guest speaker was Dr. Nathan B. Van Etten of New York City, who described the survey of the financial status of 1,000 patients treated in the free wards of the Morrisania City Hospital in May and

June, 1933. A summary of this survey is contained in the Bulletin of the Bronx County Medical Society of February, 1934.

The survey was along strictly economic lines and was conducted by representatives of a financial house who were not swayed by sentiment. The percentage of patients in various economic groups was as follows:

Class	Groups of Patients	Per Cent
1	Not able to pay	58.3
2	Able to pay	11.8
3	Can pay with help of other members of the family	10.7
4	Gave false address	8.5
5	Border line. Can possibly pay a private physician, or get credit, or pay minimum rates in a semi-private institution	10.7

Conditions in the Morrisania City Hospital are typical of those prevailing in the free wards of other hospitals of New York City and probably of hospitals in smaller places. The practical advice given by Dr. Van Etten was that the Practitioners' Club of Passaic should make a survey of free patients of Passaic similar to that of the Bronx Hospital; and then plan to correct the defects of the system.

There was an animated discussion of free treatment in Passaic County, lasting over an hour. Mr. W. Scott, Assistant Superintendent of the Passaic General Hospital, expressed the willingness of the hospital authorities of Passaic to attempt the control of free treatments; and as evidence of their sincerity, the Bi-County Hospital Council, had recently been formed by representatives of all the public hospitals of Passaic and Bergen Counties. His hospital will give emergency treatment to anyone, but he believes that steps should be taken to make every person pay according to his ability.

There was considerable discussion about the unsatisfactory relations with the Emergency Relief Administration, arising largely from two conditions: (1) The delay of the doctors in insisting on agreements with the municipal authorities regarding medical services to the indigent; and (2) the system of employing physicians on salary to treat the poor.

Dr. John Ryan, the Health Officer of Passaic, stated that the Board of Health would like to have the family doctors assume the responsibility for giving the diphtheria immunizations, but the health department had to assume it because the physicians had not done so. On the other hand, one of the doctors said that the family physicians were not giving the immunizations because patients could get them free at the public clinics.

Dr. Van Etten in closing complimented the physicians for their frankness and friendliness in discussing local conditions; and repeated his advice to institute a survey of local conditions, and devise specific remedies for the conditions that were disclosed.

SALEM COUNTY

William H. James, M.D., Reporter

The regular monthly meeting of the Salem County Medical Society was held on February 14. Medical service topics discussed were the emergency relief and the treatment of cases employed by the C. W. A.

The representative of the State Group Medical Health and Accident Insurance was present and explained the details of accident insurance for the physician and the exceptional benefits offered by the State Group Insurance Plan.

The meeting closed with refreshments.

SOMERSET COUNTY

J. L. Young, M.D., Reporter

The regular meeting of the *Somerset County Medical Society* was held at the Nurses' Home, Somerset Hospital on February 8, 1934, at 8.45 P. M. with fifteen members present.

Dr. Bruce Massey of Somerville, Dr. Louis R. Panigrosso of Raritan, Dr. John M. Cook of Bound Brook, and Dr. Nicholas Reals of Manville, were elected to membership.

Dr. Ely the Chairman of the E. R. A. Medical Advisory Committee informed the Society on the recent developments in respect to the E. R. A. and the Medical Society.

Dr. Lawton representing the censors' reported on the Calco matter which up to the time of the previous meeting had not been cleared up due to the lack of evidence against Calco's chiropractor. The Society was informed by the secretary that to his knowledge the chiropractor was moved from his post in the first aid department to one of non-medical character, and that his place was filled by a regular doctor of medicine.

The death of one of our members, Dr. J. A. Allis, was brought to the attention of the Society. A committee for resolutions was appointed and the committee consists of Drs. Field, Meigh and Stillwell.

Since our Society up to this time has not entered into the statewide public health program, the matter was discussed, and a committee of seven was appointed for this program. The committee consists of Drs. Brittain (chairman), Cooper, Flint, Meigh, Piggott, Stillwell and Sferra.

Our guest speakers were Assemblyman John J. Rafferty of Middlesex Boro, Assemblyman Dr. J. W. McKenstry of Jamesburg, Assemblyman Dr. Marcus W. Newcomb of Browns' Mills, N. J., and State Executive Secretary, Dr. LeRoy A. Wilkes. Dr. Scammell of Trenton, the Counsellor for the Third District, also addressed us.

Light refreshments were served at the close of the meeting.

Woman's Auxiliary

EXECUTIVE BOARD MEETING

Mrs. James North, Chairman of Publicity and Reporter to State Journal

The regular Executive Board meeting of the Woman's Auxiliary to the Medical Society of New Jersey was held at the Douglas Hotel in Newark on Monday, March 9, 1934, at 10.30 a. m., with the President, Mrs. Harry Varsil Hubbard, in the chair; and Mrs. Dan Renner, Secretary pro tem.

Mrs. Hubbard asked that all county Presidents either send or hand in a complete report of the year's work at the business meeting June 6 in Atlantic City, and to read only a short résumé of the main parts.

It was voted to contribute \$50 toward the expenses of a delegate to the National Auxiliary meeting in Cleveland June 11, 12, 13.

Materials for our state exhibit at the convention in Cleveland should be sent to Mrs. James North, 6 North Haverford Avenue, Margate City, N. J.

A motion was carried to include county Presidents on the State Executive Board.

Mrs. Samuel L. Salasin, Chairman on entertainment, reported on plans for the luncheon and dinner dance to be held June 6 at Haddon Hall.

Mrs. Theodore Teimer, Chairman of the Widows and Orphans Society, urged the Auxiliary to secure new members.

Dr. Frederic J. Quigley, President of the Medical Society of New Jersey, spoke on the necessity of having a speakers' bureau in each county to address lay groups; also for the Auxiliary to prepare to assist in the passage of bills, such as the licenture bill to forbid anyone not practicing medicine or surgery to use the title of Dr. or doctor.

Twenty-four members were present.

Atlantic County

Reported by Mrs. Manuel Malley

Mrs. Joseph Poland, President, presided at the regular meeting of the Woman's Auxiliary to the Atlantic County Medical Society, held in the Blue Room of the Chalfonte Hotel on March 9, 1934, at 2 o'clock.

A letter from Mr. Howard W. Armbruster was read, which explained the faults of the Copeland-Tugwell Bill and how it would void the efficiency of the Pure Food and Drugs Act. A discussion was held on these points, and the members were again urged to register their objections to the Copeland-Tugwell Bill with their Congressmen.

Mrs. Edwin H. Harvey brought in the report of the Nominating Committee and announced the following candidates: President, Mrs. James North; First Vice-President, Mrs. Carl A. Surran; Second Vice-President, Mrs. Daniel Renner; Treasurer, Mrs. Robert A. Bradley; Recording Secretary, Mrs. Lawrence A. Wilson; Corresponding Secretary, Mrs. Manuel J. Malley. No further nominations were made.

Plans were started for the annual Spring luncheon, and the arrangements were placed in the hands of Mrs. Louis Rosenberg.

Mrs. Carl Surran reported that a needy family was being supplied with milk this month, and if no other applications were made by members, this family would receive milk for another month.

Mrs. Poland asked all members to be present at the April meetings, when elections and installation of officers will be held.

Members present at this meeting: Mrs. Joseph Poland, Mrs. James North, Mrs. Bernard Crane, Mrs. Robert A. Bradley, Mrs. Lawrence A. Wilson, Mrs. Manuel J. Malley, Mrs. Samuel Salasin, Mrs. Samuel Gorson, Mrs. R. A. Williams, Mrs. David Weeks, Mrs. John Massey, Mrs. Louis Rosenberg, Mrs. Carl A. Surran, Mrs. Milton Ireland, Mrs. Sidney Rosenblatt, Mrs. Mildred Sinkinson, Mrs. Charles J. Cooney and Mrs. Edwin H. Harvey.

Gloucester County

Reported by Mrs. Henry B. Diverty

Colonial Tea Party—The Woman's Auxiliary to the Gloucester County Medical Society had a "Colonial Tea Party" at the home of one of the members, Mrs. William Brewer, Cooper Street, Woodbury, on Washington's Birthday. Each member was privileged to bring a guest. Despite the bad weather prevailing, more than fifty guests were present.

The Brewer home was a very fitting place for the occasion. Mrs. Brewer is the possessor of several large steel engravings of Revolutionary days, one of them of our first President. These decorate the spacious hall and reception room, where the party was held. American flags, large and small, added largely to the decoration.

The officers of the society and the committee were dressed in Colonial costumes as they received the guests.

The program was interesting and enjoyable. All joined in singing "America" and other national songs led by Mrs. Crain.

Guessing games were next on the program, conducted by Mrs. Pegad. The most apt at each was given a reward of merit.

Mrs. Hollingsworth gave several short readings appropriate to the occasion, which were greatly enjoyed by all. Her Colonial costume, the dressing of her hair, etc., was most attractive. After singing again the songs of Colonial days, the guests were ushered into the dining room, where Colonial decorations were carried out. Red, white and blue candles, flowers, little silk flags in some of the dainty cakes, a cherry on others, beautiful linen, china, etc.

Regular Meeting: The Woman's Auxiliary to the Gloucester County Medical Society held its regular monthly meeting March 15, at Hotel Pitman, in Pitman, at the same time that the County Medical Society met. After the doctors finished their program, the ladies were invited to join them in the dining room, where they enjoyed a light repast and a delightful time socially.

Obituaries

DR. JERE A. ALLIS

ALLIS, Dr. Jere A., of Basking Ridge, died in Overlook Hospital, Summit, February 3, of septicemia after a week's illness.

Dr. Allis was 70 years old, and was born at Leonardsville, N. Y., graduating from the College of Physicians and Surgeons, New York, in 1889.

He served as Captain in the Army during the World War and was for five years and up to the time of his death physician of the Bernardsville Borough and Bernards Township school system. He took up his practice and residence in Basking Ridge, seven years ago after practicing in New York, Plainfield and Montclair.

Surviving him are his wife, Mrs. Bertha E. S. Allis and one sister, Mrs. Nathan Lewis of Plainfield.

DR. J. OLIVER McDONALD

McDONALD, J. Oliver, M.D., a member of the Board of Health and of the Mercer County Medical Society of New Jersey, died on March 29, 1934, in the Medical Center, New York City, after an operation for a chronic intestinal ulcer from which he had suffered for over three years.

Dr. McDonald was born in Englishtown on April 8, 1889, and was educated in Princeton College and the College of Physicians and Surgeons of Columbia University. He was an alumnus of the Presbyterian Hospital and the Sloane Maternity Hospital and a member of the American College of Physicians. He practiced pediatrics in Trenton, and was attending physician in the Municipal Hospital. He was connected with the State Board of Health for over twenty years, and at one time was chief of the Bureau of Sanitary Shellfish Control. He was an authority on prints and had accumulated an extensive collection by well-known artists.

DR. WLADYSLAW J. A. SCHWARZ

SCHWARZ, Dr. Wladyslaw J. A., aged 73 years, a practicing physician of Jersey City for 32 years, died on March 4, at his home, 269 Cator Avenue, from angina pectoris, after several previous attacks.

He was born in Posen, Poland, and graduated in pharmacy in the Frederick Wilhelms University, Berlin. He came to New York in 1891 and conducted drug stores in Manhattan, Brooklyn and Jersey City. He studied medicine and was licensed in 1902. He practiced medicine in Jersey City, and was the first physician in the city to use an automobile in his practice.

Dr. Schwarz was active in organizing the Polish-American forces in the World War, and was decorated by the Republic of Poland for his services. He was visiting physician to St. Ann's Home. He was a linguist, and was proficient in Latin and Greek.

He leaves two sons, who are practicing medicine, Dr. B. T. D. Schwarz, in Jersey City, and Dr. H. J. Schwarz in North Bergen.

DR. FREDERICK E. LAMBERT

LAMBERT, Dr. Frederick E., of 157 Ocean Avenue, Jersey City, died of heart disease Thursday night while visiting a patient.

He was 73 years old and was born in Paterson. He had practiced medicine in Jersey City for the past thirty-five years and was the first president of the Jersey City Board of Health. He was a graduate of the Long Island College of Medicine. He was visiting physician to St. Ann's Home, Jersey City, and was on the staff of Christ Hospital, Jersey City. He was a member of the American Medical Association, Hudson County Medical Society and the Practitioners' Club.

DR. JOSEPH NICHOLSON

A special meeting of the Camden County Medical Society was held at the Camden City Dispensary Building Saturday, March 17, 1934, in honor of Dr. Joseph Nicholson, an Honorary Member of this Society. The following memorial, prepared by Drs. A. Haines Lippincott, Howard F. Palm, and Edward A. Y. Schellenger, was adopted:

Whereas: The Divine Providence has in His wise judgment seen fit to remove from this earthly sphere, Dr. Joseph L. Nicholson;

Whereas: Dr. Nicholson, born in this county, a graduate of the University of Pennsylvania of the Class of 1890. He served as House Doctor in Blockley and Cooper Hospital. Following his internship, he practiced his chosen profession in Camden for a period of forty years, enjoying a large practice. He was a member of the Surgical Staff of the Cooper Hospital until the time of his retirement a few years ago. He was a highly respected citizen of this city, a skillful surgeon, an able physician, and a wise counselor, and was beloved by all who knew him;

Be it resolved: That this Resolution be embodied in the minutes of this Society and that a copy be sent to his family.

Eulogies of Dr. Nicholson were given by Dr. Alexander MacAlister and Dr. E. H. Palm.

Communications

BOARD OF MEDICAL EXAMINERS

Following is a report of the Board's activities in enforcing the Medical Practice Act since our last report, which appeared in the Journal of December, 1933, page 865:

October 4, 1933, Lulu Sclator, "a cancer specialist", of Wildwood, was found guilty of practicing medicine and surgery without a license and the penalty was imposed.

October 4, 1933, Samuel Dixon Mayhew, M.D., of Wildwood, whose license to practice medicine and surgery was revoked by the Board on January 13, 1932, paid the penalty for practicing medicine without a license.

October 9, 1933, Alexander Maisel, a masseur, and his assistant, Elizabeth Ignatz, a masseuse, operating at the Casino in Bradley Beach, were found guilty of practicing medicine without a license by the Judge of Monmouth County Court of Common

Pleas. They were unable to pay the penalty and Maisel was committed to the County Jail for fifteen days, and Ignatz for ten days.

On October 27, the Judge of the Cumberland County Court of Common Pleas found August Miller, a licensed chiropractor, of Millville, guilty of practicing medicine without a license. Miller refused to pay the penalty and was committed to the County Jail for ten days. The Judge found Scott H. Rosser, a chiropractor, of Bridgeton, guilty of practicing medicine without a license and imposed the penalty. On the same day the Judge found Ellsworth Pierce, a naturopath, of Bridgeton, guilty of practicing medicine without a license. He was unable to pay the \$500 penalty imposed, and as it was the fourth offence, the Judge committed him to jail for 100 days.

November 8, 1933, Edward Carroll, a licensed osteopath, of Newark, paid the penalty for practicing medicine without a license.

On November 8, 1933, George A. Miller, of Magnolia, and Eugene A. Latta, of Mt. Ephraim, registered pharmacists, paid the penalty for practicing medicine without a license.

November 9, 1933, Frank Krak, who was using the name of F. W. Williams and who held himself out as F. W. Williams, M.D., Physician and Surgeon, and had a fully equipped medical office at 1133 Main Street, Paterson, was found guilty of practicing medicine without a license. Russell K. Johnston, a chiropractor, practicing with Williams at the same address, was also found guilty of practicing medicine without a license. The penalty prescribed by the statute was imposed by the Judge in each case.

November 28, 1933, Joseph Grigat, "a tuberculosis specialist", of Irvington, was found guilty of practicing medicine without a license by the Judge of the First District of Newark and paid the penalty. On the same date, Franklin Tanney, who conducts the Scientific Research Laboratories at Branford Place, Newark, and who diagnoses all ailments by means of an urine analysis and prescribes diets and colonic irrigations, was found guilty of practicing medicine without a license by the Judge of the First District Court of Newark. He refused to pay the penalty and was committed to jail.

On November 30, 1933, Mary Antolik, of Newark, paid the penalty for prescribing medicine without a license. Mrs. Antolik prescribed drugs. Patients were sent to her from the Spiritual Circle of Truth which holds meetings at 158 Springfield Avenue, Newark.

December 28, 1933, Harry L. Wiseman, of Neptune Township, an agent for the Scientific Research Laboratories, conducted by Franklin Tanney, who was found guilty of practicing medicine without a license on November 28, was found guilty of practicing medicine without a license by the Judge of Asbury Park District Court.

On January 23, 1934, the following persons pleaded guilty before the Judge of the First District Court in Newark to the charge of practicing medicine without a license.

Joseph Ilyea, a naturopath, located at 265 Sherman Avenue, Newark.

Bruce Whittier, a representative of the Hubert

Laboratories, of East Orange, who was offering the vibra chain as a relief for many diseases. The vibra chain is a woven wire chain insulated with various kinds of beads, prescribed to be worn around the neck as a necklace. The agent selected the length of the necklace according to the part of the body affected. The literature outlines the theory that disease is caused by a disturbance of the fundamental electric vibrations of the body, and that the chain acts as an aerial bringing in other vibrations and giving out radiations which correct the disturbances.

Richard Scarlett, a doctor of metaphysics and psychoanalyst, located at 254 Clinton Avenue, Newark. Scarlett prescribed herbs for his patients.

Ferdinand Buettel, a naturopath, located at 1033 Clinton Avenue, Irvington. This was the second offence, the defendant having pleaded guilty to a similar charge in 1926 before the Judge of the Elizabeth District Court.

On October 14, 1933, the Board revoked the license to practice midwifery of Marie Manager, of Newark, on conviction of the crime of criminal abortion.

On November 22, 1933, the Board revoked the registration of the medical diploma of Irvin W. Kirk, of Millville, for the practice of criminal abortion.

James J. McGuire, Secretary.

EMERGENCY RELIEF IN TEXAS

An editorial in the March number of the Texas State Journal of Medicine describes the Texas E. R. A. system, whose organization is similar to that of New Jersey. The Journal says:

"The plan of medical relief as heretofore agreed upon between the medical profession and the Texas Relief Commission is working smoothly and with a minimum of complaint. The Texas Relief Commission is entirely coöperative, and complaints made through the office of the Secretary of the State Medical Association are receiving immediate and sympathetic attention at Austin.

It may be that medical relief is more necessary than any other type. Here will come into play, as in no other instance, the coöperative disposition of the county administration and the committee of the county medical society."

IMPORTANCE OF COUNTY SOCIETIES

The following editorial in the January issue of the *Maine Medical Journal* sets forth the importance of county society meetings:

"As the county associations are the constituent bodies which make up the State and American Medical Associations, the various county meetings should be considered of more importance than is too frequently the case. It is these bodies which determine the policies of the large organizations. It is in these meetings that every member has the opportunity of voicing his ideas on these same policies. The officers and delegates of the county association are bound to reflect the will of the majority of its members as it will be expressed through these meetings." * * *

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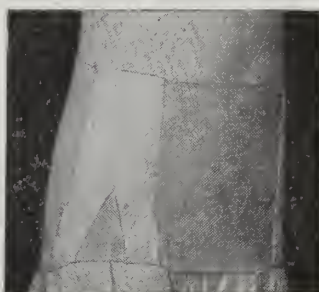
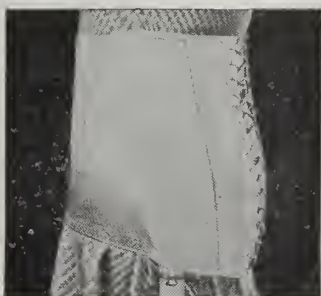
MEDICAL SOCIETY OF NEW JERSEY

PLACE	NAME AND ADDRESS	TELEPHONE
ORANGE, N. J.	Mosler, Abram, Ph. G., 268 Main St.	ORange 3-2626
EAST ORANGE, N. J.	Mosler, Thomas A., Ph. G., 144 Harrison St.	ORange 5-7430
NEWARK, N. J.	Marquier, A. F., 1041 So. Orange Ave.	ESsex 3-7722

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H. W. NAFAY , <i>Secretary</i> (1935)	New Brunswick	ANDREW F. MCBRIDE (1934)	Paterson
FREDERIC J. QUIGLEY	Union City	BLASE COLE (1935)	Newton
LANCELOT ELY	Somerville	R. M. A. DAVIS (1935)	Salem
MARCUS W. NEWCOMB	Brown's Mills	JAMES S. GREEN (1935)	Elizabeth
FRANCIS R. HAUSSLING	Newark	WALT P. CONAWAY (1936)	Atlantic City
J. BENNETT MORRISON	Newark	WILLIAM G. HERRMAN (1936)	Ashbury Park
ELIAS J. MARSH	Paterson	HARRY R. NORTH (1936)	Trenton
		CHARLES B. SMITH (1936) (Died Dec. 19, 1933)	Washington

COUNCILORS

First District (Union, Warren, Morris and Essex Counties)	CHRISTOPHER C. BELING, Newark (1936)
Second District (Sussex, Bergen, Hudson and Passaic Counties)	S. T. SNEDECOR, Hackensack (1935)
Third District (Mercer, Middlesex, Somerset and Hunterdon Counties)	F. G. SCAMMELL, Trenton (1934)
Fourth District (Camden, Burlington, Ocean and Monmouth Counties)	JAMES A. FISHER, Ashbury Park (1936)
Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties)	ALDRICH C. CROWE, Ocean City (1935)

DELEGATES

Delegates to the American Medical Association

WALT P. CONAWAY	Term expires 1934
JOHN F. HAGERTY	" " 1934
E. R. MULFORD	" " 1935
A. HAINES LIPPINCOTT	" " 1935

Alternate Delegates

PHILIP MARVEL	Term expires 1934
GEORGE H. SEXSMITH	" " 1934
S. B. ENGLISH	" " 1935
STEPHEN T. QUINN	" " 1935

SCIENTIFIC SECTIONS

Chairmen for the Annual Meeting of 1934

Section	Chairman
Eye, Ear, Nose, Throat	S. T. HUBBARD, Hackensack
Pediatrics ..	WALTER B. STEWART, 8 N. Tallahassee Ave., At. C'y
Radiology	GEO S. REITTER, 144 Harrison St., East Orange
School Physicians ..	A. G. IRELAND, Trenton Trust Bldg., Tr'n

STANDING COMMITTEES

Committee on Scientific Work

LOUIS C. LANGE , <i>Chm.</i> , Weehawken	Term expires 1934
RALPH K. HOLLINSBED , Westville	" " 1935
CLARENCE C. ANDREWS , Atlantic City	" " 1934

Committee on Publication

HENRY C. BARKHORN , <i>Chm.</i> , Newark	Term expires 1936
EDWARD J. ILL , Newark	" " 1934
LINN EMERSON , Orange	" " 1935
FREDERIC J. QUIGLEY	Ex-officio
J. BENNETT MORRISON	Ex-officio

Committee on Finance and Budget

HARRY R. NORTH , <i>Chm.</i> , Trenton	Term expires 1939
ALFRED STAHL	" " 1934
JAMES S. GREEN	" " 1935
HERSCHEL PETTIT	" " 1936
WILLIAM G. HERRMAN	" " 1937
WILLIAM J. SWEENEY	" " 1938

Committee on Program and Arrangements

WILLIAM J. CARRINGTON , <i>Chm.</i> , Atl. City	Term expires 1935
JOHN W. GRAY , Newark	" " 1934
WILLIAM D. OLMSTEAD , Atlantic City	" " 1936
FREDERIC J. QUIGLEY , Union City	Ex-officio
J. BENNETT MORRISON , Newark	Ex-officio

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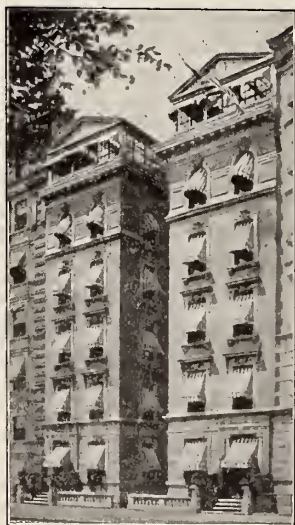
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ANNUAL MEETING—JUNE 5, 6, 7, 1934

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THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Offices of the Society, 137 East State Street, Trenton, N. J.

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MAY, 1934

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OF THE

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OF

THE MEDICAL SOCIETY OF NEW JERSEY

FOR THE YEAR 1934

Prepared by J. Bennett Morrison, Secretary, assisted by the Secretaries and Treasurers of the County Societies.

This list is composed from the identical lists submitted by the Treasurers of the various County Medical Associations. If there are any errors in your name or address please take the matter up with the Treasurer of your County Medical Society and have the proper correction made so that the error will not be carried on next year.

The Alphabetical List is compiled in the office of the Secretary.

FELLOWS

The dates represent the year of election as President. Those marked thus (*) are deceased.

*Robert McKean	1766	*Augustus R. Taylor	1822
*William Burnett	1767	*William B. Ewing	1823
*John Cochran	1768	*Peter I. Stryker	1824
*Nathaniel Scudder	1770	*Gilbert S. Woodhull	1825
*Isaac Smith	1771	*William D. McKissack	1826
*James Newell	1772	*Isaac Pierson	1827
*Absalom Bainbridge	1773	*Jeptha B. Munn	1828
*Thomas Wiggins	1774	*John W. Craig	1829
*Hezekiah Stites	1775	*Augustus R. Taylor	1830
* * *		*Thomas Yarrow	1831
*John Beatty	1782	*Fitz Randolph Smith	1832
*Thomas Barber	1783	*William Forman	1833
*Lawrence Van Derveer	1784	*Samuel Hayes	1834
*Moses Bloomfield	1785	*Abraham P. Hagerman	1835
*William Burnett	1786	*Henry Van Derveer	1836
*Jonathan Elmer	1787	*Lyndon A. Smith	1837
*James Stratton	1788	*Benjamin H. Stratton	1838
*Moses Scott	1789	*Jabez G. Goble	1839
*John Griffith	1790	*Thomas P. Stewart	1840
*Lewis Dunham	1791	*Fred S. Schenck	1841
*Isaac Harris	1792	*Zachariah Read	1842
* * *		*Abraham Skillman	1843
*Elisha Newell	1795	*George R. Chetwood	1844
* * *		*Robert S. Smith	1845
*Jonathan F. Morris	1807	*Charles Hannah	1846
*Peter I. Stryker	1808	*Jacob T. B. Skillman	1847
*Lewis Morgan	1809	*Samuel H. Pennington	1848
*Lewis Condict	1810	*Joseph Fithian	1849
*Charles Smith	1811	*Elias J. Marsh	1850
*Matthias H. Williamson	1812	*John H. Phillips	1851
*Samuel Forman	1814	*Othniel H. Taylor	1852
*John Van Cleve	1815	*Samuel Lilly	1853
*Lewis Dunham	1816	*Alfred B. Dayton	1854
*Peter I. Stryker	1817	*James B. Coleman	1855
*John Van Cleve	1818	*Richard M. Cooper	1856
*Lewis Condict	1819	*Thomas Ryerson	1857
*James Lec	1820	*Isaac P. Coleman	1858
*William G. Reynolds	1821	*John R. Sickler	1859

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*William Elmer	1860	*David C. English	1897
*John Blane	1861	*Clausius R. P. Fisher	1898
*John Woolverton	1862	*Luther M. Halsey	1899
*Theo. R. Varick	1863	*William Pierson	1900
*Ezra M. Hunt	1864	*John D. McGill	1901
*Abraham Coles	1865	*Edmund L. B. Godfrey	1902
*Benjamin R. Bateman	1866	*Henry Mitchell	1903
*John C. Johnson	1867	*Walter B. Johnson	1904
*Thomas J. Corson	1868	*Henry W. Elmer	1905
*William Pierson	1869	*Alexander Marcy, Jr.	1906
*Thomas F. Cullen	1870	Edward J. Ill	1907
*Charles Hasbrouck	1871	*David St. John	1908
*Franklin Gauntt	1872	*Benjamin A. Waddington	1909
*Thomas J. Thomason	1873	*Thomas H. Mackenzie	1910
*Géorge H. Larison	1874	*Daniel Strock	1911
*William O'Gorman	1875	*Norton L. Wilson	1912
*John V. Schenck	1876	*Enoch Hollingshead	1913
*Henry R. Baldwin	1877	*Frank D. Gray	1914
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*Alexander N. Dougherty	1880	*William G. Schaufler	1917
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*John W. Snowden	1882	*Gordon K. Dickinson	1919
*Stephen Wickes	1883	*Philander A. Harris	1920
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*Beriah A. Watson	1889	James S. Green	1926
*James S. Green	1890	Walt P. Conaway	1927
*Elias J. Marsh	1891	Ephraim R. Mulford	1928
*George T. Welch	1892	Andrew F. McBride	1929
*John G. Ryerson	1893	George N. J. Sommer	1930
*Obadiah H. Sproul	1894	John F. Hagerty	1931
*William Elmer	1895	A. Haines Lippincott	1932
*Thomas J. Smith	1896	Frederic J. Quigley	1933

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*John Condict, Orange, N. J.	1830	*Thomas Addis Emmett, New York	1884
*Usher Parsons, Rhode Island	1839	*Isaac E. Taylor, New York	1884
*Reuben D. Murphy, Cincinnati	1839	*D. Hayes Agnew, Philadelphia	1886
*Alban G. Smith, New York	1839	*Joseph Leidy, Philadelphia	1886
*Willard Parker, New York	1842	*Frederick S. Dennis, New York	1893
*Valentine Mott, New York	1843	*John H. Ripley, New York	1893
*Johnathan Knight, New Haven	1848	*Virgil P. Gibney, New York	1893
*Nathaniel Chapman, Philadelphia	1848	*William Pierson, Orange, N. J.	1894
*John H. Stephens, New York	1848	*Abraham Jacobi, New York	1896
*John C. Warren, Boston	1849	*Virgil M. D. Marcy, Cape May City	1896
*Lewis C. Beck, New York	1850	*Samuel H. Pennington, Newark, N. J.	1897
*John C. Torrey, New York	1850	*Alfred A. Woodhull, Princeton, N. J.	1897
*George B. Wood, Philadelphia	1853	*J. Leonard Corning, New York	1902
*Horace A. Buttolph, Short Hills, N. J.	1854	*John Allen Wyeth, New York	1903
*Ashbel Woodward, Franklin, Conn.	1861	William K. Van Reypen, U. S. N.	1903
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*Stephen Wickes, Orange, N. J.	1868	*Albert Vander Veer, Albany, N. Y.	1907
*Samuel Oakley Vanderpool, Albany, N. Y.	1872	Charles K. Mills, Philadelphia	1917
*Joseph Parrish, Burlington, N. J.	1872	Richard C. Cabot, Boston	1917
*Ferris Jacobs, Lelhi, N. Y.	1872	George W. Crile, Cleveland, Ohio	1917
*Charles A. Lindsley, New Haven, Conn.	1872	*John B. Deaver, Philadelphia	1917
*William Pepper, Philadelphia	1876	*William J. Chandler, Lawtew, Florida	1923
*S. Weir Mitchell, Philadelphia	1876	Edward J. Ill, Newark, N. J.	1925
		Joseph E. Raycroft, Princeton, N. J.	1930

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E. R. MOLFORD	" " 1935
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STEPHEN T. QUINN	" " 1935

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RADIOLOGY	GEO. S. REITZER, 144 Harrison St., East Orange
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CLARENCE C. ANDREWS , Atlantic City	" " 1934

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LYNN EMERSON , Orange	" " 1935
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HERSCHEL PETTIT	" " 1936
WILLIAM G. HERRMAN	" " 1937
WILLIAM J. SWEENEY	" " 1938

Committee on Program and Arrangements

WILLIAM J. CARRINGTON , <i>Chm.</i> , Atl. City	Term expires 1935
JOHN W. GRAY , Newark	" " 1934
WILLIAM D. OLMSTEAD , Atlantic City	" " 1936
FREDERIC J. QUIGLEY , Union City	Ex-officio
J. BENNETT MORRISON , Newark	Ex-officio

Committee on Honorary Membership

THOMAS W. HARVEY , <i>Chm.</i>	Term expires 1934
W. E. DARNALL	" " 1935
EPHRAIM R. MOLFORD	" " 1936

Committee on Hospitals and Medical Education

HARRY H. SATCHWELL , <i>Chm.</i>	Term expires 1936
WILLIAM W. BROOKE	" " 1935
ARCANGELO LIVA	" " 1934
JOHN H. CARLISLE	STUART Z. HAWKES
CHARLES H. DE T. SHIVERS	CHARLES B. KELLEY
WILLIAM R. LITTLE	EARL H. SNAVELY
LOUIS A. PYLE	ELMER P. WEIGEL
DAN S. RENNER	HUGH H. TYNDALL
J. VINCENT SMITH	

Committee on Medical Defense

C. C. BELING , <i>Chm.</i>	EDGAR A. ILL
JOHN C. MCCOY	WILLIAM J. ARLITZ
E. REISSMAN	

Committee on Insurance

FRANK W. PINNEO , <i>Chm.</i>	CHESTER I. ULMER
BARCLAY S. FUHRMANN	A. DUNBAR HUTCHINSON
EDMUND N. HUFF	WAYNE W. HALL
WARREN D. ROBBINS	

Welfare Committee

FREDERIC J. QUIGLEY , <i>Chm.</i>	Union City
SAMUEL ALEXANDER	Park Ridge
WILLIAM H. ARESON	Montclair
LAWRENCE H. BLOOM	Phillipsburg
JACK BLUMBERG	Elizabeth
JOHN C. CLAYTON	Freehold
A. H. COLEMAN	Clinton
JOSEPH G. COLEMAN	Hamburg
EDWIN H. COWARD	Atlantic City
GEORGE F. DANDOIS	Wildwood
DAVID W. GREEN	Salem
D. L. HAGGERTY	Trenton
EUGENE G. HERBERNER	Lakewood
DAVID A. KRAKER	Newark
ANDERSON A. LAWTON	Somerville
THOMAS B. LEE	Camden
THOMAS K. LEWIS	Camden
E. J. LUIPPOLD	Weehawken
THOMAS E. MANLY	Paterson
ROBERT L. MCKIERMAN	New Brunswick
CHARLES H. MITCHELL	Trenton
WATSON B. MORRIS	Millburn
J. BENNETT MORRISON	Newark
JULIA C. MUTCHLER	Dover
STANLEY H. NICHOLS	Long Branch
B. S. POLLAK	Secaucus
HARRY L. ROGERS	Riverton
DAVID W. SCANLAN	Atlantic City
MILLARD F. SEWALL	Bridgeport
ROBERT STOCKFISH	Jersey City
GEORGE T. TRACY	Beverly
CHESTER I. ULMER	Gibbstown
H. ROY VAN NESS	Newark
H. B. WILSON	Hackensack
E. LEROY WOOD	Newark

*Deceased.

STANDING COMMITTEES—(Continued)

MEMBERS OF THE STATE SOCIETY NOMINATING COMMITTEE FOR 1934

COUNTY	DELEGATE	ALTERNATE
ATLANTIC	WALT P. CONAWAY, 1723 Pacific Ave., Atlantic City	
BERGEN	ARCANGELO LIVA, 5 Pangborn Pl., Hackensack	
BURLINGTON	HARRY L. ROGERS, Riverton	E. W. RODMAN, Beverly
CAMDEN	THOMAS B. LEE, 622 Cooper St., Camden	
CAPE MAY	CLARENCE W. WAY, Sea Island City	
CUMBERLAND	H. G. MILLER, Millville	L. MYATT, Bridgeton
ESSEX	A. STAHL, 55 Clinton av., Newark	A. C. ZEHNDER, Newark
GLOUCESTER	R. K. HOLLINSHED, Westville	C. I. ULMER, Gibbstown
HUDSON	JOSEPH F. LONDRIGAN, 535 Washington St., Hoboken	H. ALEXANDER, Hoboken
HUNTERDON	A. H. COLEMAN, Clinton	S. B. ENGLISH, Glen Gardner
MERCER	HARRY R. NORTH, 160 W. State St., Trenton	D. L. HAGGERTY, Trenton
MIDDLESEX	JOSEPH S. MARIS, Woodbridge	
MONMOUTH	WILLIAM G. HERRMANN, Asbury Park	
MORRIS	BERNARD G. McMAHON, Morristown	
OCEAN	EUGENE HERBENER, Lakewood	
PASSAIC	J. V. BERGIN, Passaic	J. H. CARLISLE, Passaic
SALEM	R. M. A. DAVIS, Salem	
SOMERSET	D. S. RENNER, Skillman	
SUSSEX	F. P. WILBUR, Franklin	
UNION	STEPHEN T. QUINN, 1143 E. Jersey St., Elizabeth	
WARREN	LAWRENCE BLOOM, Phillipsburg	W. H. VARNEY, Washington H. BALDAUF, Belvidere

Chairman of Committee and representative of the Fellows,
A. Haines Lippincott, 406 Cooper St., Camden

SPECIAL COMMITTEES

Reference Committee on Constitution
and By-Laws

FREDERIC J. QUIGLEY, *Chm.*, 4622 Hudson Blvd., Union City
GEORGE H. LATHROPE, 965 Broad St., Newark
J. BENNETT MORRISON, 66 Milford Ave., Newark

Public Health Committee

STANLEY H. NICHOLS, *Chm.*, Asbury Park
*WILLIAM G. SCHAUFFLER, 21 Morven Pl., Princeton
*F. C. JOHNSON, 51 Livingston Ave., New Brunswick
F. C. JOHNSON, 51 Livingston Ave., New Brunswick
JULIUS LEVY, Dept. of Health, Plane & William Sts., N'w
ALLEN G. IRELAND, Trenton Trust Bldg., Trenton

Committee to Study State Medicine

FRANCIS H. TODD, *Chm.*, Auburn St., Paterson
HENRY C. BARKHORN, 45 Johnson Ave., Newark
*W. BLAIR STEWART, N. Carolina & Pacific Aves., At. C'y
JOHN H. ROWLAND, 159 New St., New Brunswick
BARCLAY S. FUHRMANN, Flemington

Committee on Matters Pertaining to Workmen's
Compensation Act

WM. H. ARESON, 153 Bellv. Ave., U. Montclair
DAVID A. KRAKER, 31 Lincoln Park, Newark
FRANCIS R. HAUSSLING, 661 High St., Newark
E. LE ROY WOOD, 192 Roseville Ave., Newark
H. R. VAN NISS, 444 Parker St., Newark
J. B. MORRISON, 66 Milford Ave., Newark

SUB-COMMITTEES APPOINTED BY THE CHAIRMAN OF THE WELFARE COMMITTEE

Committee on Observation of Proposed
Legislation

D. LEO HAGGERTY, *Chm.*, 227 N. Warren St., Trenton
PAUL M. MEGRAY, 405 Cooper St., Camden
HARRY R. NORTH, 160 West State St., Trenton
F. G. SCAMMELL, 40 S. Clinton Ave., Trenton
JOSEPH M. KUDER, Mt. Holly

Committee on Expert Testimony

J. F. LONDRIGAN, *Chm.*, 535 Washington St., Hoboken
ELBERT S. SHERMAN, 671 Broad St., Newark
C. H. SCHLICHTER, 556 N. Broad St., Elizabeth

Committee to Consider Narcotic Legislation

CHARLES H. SCHLICHTER, 556 N. Broad St., Elizabeth
JAMES S. GREEN, 463 N. Broad St., Elizabeth
J. B. MORRISON, 66 Milford Ave., Newark
G. N. J. SOMMER, 120 West State St., Trenton
C. I. ULMER, Gibbstown

*Deceased.

Committee on Health, Accident, Life and Auto-
mobile Insurance

FRANK W. PINNEO, *Chm.*, Newark
J. FINLEY BELL, Englewood
AUSTIN H. COLEMAN, Clinton
FREDERIC J. QUIGLEY, Union City
JAMES S. GREEN, Elizabeth
C. I. ULMER, Gibbstown
CLARENCE W. WAY, Sea Isle City
*IRVING D. WILLIAMS, New York City

Committee on Maternal Welfare

ARTHUR W. BINGHAM, 144 Harrison St., East Orange
THEODORE TEIMER, 17 Hillside Ave., Newark
GEORGE VAN VORIS WARNER, E. Front St., Red Bank
P. DU BOIS BUNTING, 712 N. Broad St., Elizabeth
JOHN F. CONDON, 686 Mt. Prospect Ave., Newark
CARL ILL, 188 Clinton Ave., Newark
WALTER B. MOUNT, 11 Seymour St., Montclair

Committee on School Health to Coöperate with
Dr. Ireland

GEORGE J. HOLNES, 17 Elizabeth Ave., Newark
*WILLIAM G. SCHAUFFLER, 21 Morven Pl., Princeton
ELBERT S. SHERMAN, 671 Broad St., Newark
WILLIAM F. COSTELLO, Dover
H. E. LONGSDORF, Mt. Holly

Committee on "Report of Committee on Costs of
Medical Care"

E. S. SHERMAN, *Chm.*, 671 Broad St., Newark
JOSEPH LONDRIGAN, 535 Washington St., Hoboken
JOHN H. ROWLAND, 159 New St., New Brunswick
JOSEPH M. KUDER, Mt. Holly
L. H. BLOOM, Phillipsburg
S. RUBINOW, 755 High St., Newark

Committee on Veteran's Bonus and Health

Legislation

ANDREW F. MCBRIDE, *Chm.*, 30 Church St., Paterson
LUCIUS F. DONOHUE, 140 W. Eighth St., Bayonne
DAVID B. ALLMAN, 104 St. Charles Pl., Atlantic City
J. C. CLAYTON, Freehold
C. A. BROKAW, 1405 North Ave., Elizabeth

Committee to Consider Legislation Regarding
Barbital and Similar Drugs

FREDERIC J. QUIGLEY, *Chm.*, 4622 Hudson Blvd., Union City
S. T. QUINN, 1143 E. Jersey St., Elizabeth
FRANCIS R. HAUSSLING, 661 High St., Newark

ANNUAL DELEGATES TO THE MEDICAL SOCIETY OF NEW JERSEY FOR 1934

ATLANTIC COUNTY

Delegates	Alternates
Harvey, E. H.	Mason, J. H.
Carrington, W. J.	Fish, C. M.
Barbash, S.	Uzzel, E. F.
Darnall, W. E.	Stern, S.
Andrews, C. L.	Corson, S. F.
*Stewart, W. B.	Poland, G.
	Goldstein, S.

BERGEN COUNTY

Morrow, J.	Sarla, M.
Liva, A.	King, C.
Finke, G. W.	Hitzemann, L.
Hallett, F. S.	Edwards, J. B.
Levitas, G. M.	Webb, W. D.
Payne, J.	Townsend, T. E.
Trossbach, H.	Pallen, Conde.
Snedecor, S. T.	Wilson, H. B.
Vroom, Wm. S.	Van Dyke, J.

BURLINGTON COUNTY

Rogers, H. L.	Darlington, E. P.
Kuder, Joseph	Imhoff, R. E.
Rodman, Warren	Metzer, Emma P.

CAMDEN COUNTY

Barrett, W. J.	Fisher, Stella M.
Hollinshed, Beulah S.	Meyer, G. P.
Hummel, E. G.	Lee, Thos. B.
Lee, Thos. B.	Palm, H. P.
Howard, J. Edgar	Lovett, Jos.
Roberts, Jos. E., Jr.	Schreck, Helen
Lewis, Thos. K.	Pike, Chas.
Glover, L. L.	Shipman, J. S.
Jack, H. W.	
Del Duca, Vincent	

CAPE MAY COUNTY

Way, Clarence
Dandois, Geo. F.
Pettitt, Herschel

CUMBERLAND COUNTY

Miller, H. G.	Butcher, Chas.
Myatt, Leslie B.	Aitken, Frank
Walker, H. B.	Van Dusen, E. H.

ESSEX COUNTY

(Expire 1934)	(Expire 1934)
Condon, John F.	Bissett, J. V.
Corwin, T. W.	Brown, Lewis
Dieffenbach, R. H.	Carbone, F. R.
Dowd, Ambrose F.	Conlon, Philip
*Griffiths, C. B.	Cook, Hugh F.
Hawkes, E. Zah	Curtis, E. A.
Ill, Chas. L.	Echikson, Jos. I.
Mitchell, A. J.	Harden, Albert S.
Philhower, Geo. B.	Hughes, Lee W.
Snavely, Earl H.	Ill, Herbert M.
Sprague, Ed. W.	Kessler, Henry M.
Telmer, Theo.	Morris, Clement
Wallhauser, H. J. F.	Muta, Samuel A.
Wherry, E. G.	Smith, Ellis L.

ESSEX COUNTY—Continued

Delegates	Alternates
(Expire 1935)	(Expire 1935)
Areson, W. H.	Baldwin, Samuel H.
Connolly, Richard N.	Blanchard, Kenneth
Epstein, Harry B.	Bianchi, A. R.
Fort, J. Irving	Chamberlain, A. R.
Gennell, Ernest	Comando, Harry N.
Gray, John W.	Crane, Chas. G.
Hanan, Jas. T.	Davies, Geo. W.
Hausling, F. R.	Devlin, Frank
Hosp, Paul H.	Horseford, F. C.
Lowrey, Jas. H.	Keller, Sidney C.
Mullin, Raymond J.	Klein, Ed. C.
Parker, John E.	Matheke, O. G.
Payne, Guy	Menk, Paul E.
Pilch, Arthur	Morgan, Browne
Rathgaber, Chas. F.	Mount, Walter B.
Rich, Charles	Richardson, Arthur
Stahl, Alfred	Sherman, A. Russell
Weber, Francis C.	Satchwell, H. H.
Wood, Earl Le Roy	Schrench, Harry
	Toye, John E.
	Warner, W. H. A.
	Yaguda, Asher

(Expire 1936)

Blackburne, Geo.
Crecca, Wm. D.
Freeman, R. D.
Hurff, J. Wallace
Ill, Edgar J.
McCauley, F. J.
Orton, Henry B.
Pinneo, Frank W.
Ranson, B. B., Jr.
Reissman, E.
Steiner, Edwin
Tansey, Wm. A.
Tarbell, H. A.
Van Ness, H. Roy
Zehnder, A. C.

(Expire 1936)

Antonius, N. A.
Barkhorn, H. C.
Coburn, J. W.
Harvey, Thos. W., Jr.
Kraker, David A.
Levy, Julius
Mancusi-Ungaro, L.
Marquis, Dean
Minard, E. L.
Parsonnet, Eugene
Siegel, Jos. W.
Tutschulte, Ernest

GLOUCESTER COUNTY

Hollinshed, R. K.	Livingood, B. A.
Pedrick, Wm.	Ristine, E. R.
Brewer, Wm.	Ulmer, C. I.

HUDSON COUNTY

(Expire 1934)	(Expire 1934)
Jaffin, A. E.	Perkel, L. L.
Hasking, A. P.	Ginsberg, G.
Freile, Wm.	Borshaw, H.
Fruendt, C. C.	Barishaw, S. B.
Sweeney, W. J.	Comora, H. C.
Klaus, H.	Daly, E. J.
Swiney, M. A.	Kooperman, B.
Londrigan, J. F.	Halligan, Earl
(Expire 1935)	(Expire 1935)
Alexander, H.	Brandenberg, L. W.
Barbarito, W. N.	Christian, Henry
Cassidy, J. M.	Dodson, L. W.
Chapman, E. J.	Doran, W. G.
Kelley, C. B.	Hernandez, M.
Luippold, E. J.	Higgins, T. A.
Nevin, J.	Kieley, E. M.
Schwarz, B. T. D.	Madaras, J. S.
Stockfish, R.	Maver, W. W.
Tidwell, H. F.	Rehman, A. P.

HUDSON COUNTY—Continued

Delegates	Alternates
Williamson, W.	Shapiro, Jos.
Woodruff, S. R.	Visconti, J.
(Expire 1936)	(Expire 1936)
Pyle, Louis A.	Mutter, A. A.
Ballinger, R. L.	Waters, E. G.
Pagliughi, J. J.	Koppel, Jos.
Maras, P. E.	Lupin, Edward
Niemeyer, C. V.	Kieley, E. M.
Perlberg, H. J.	Madaras, J. S.
Pollak, B. S.	Harter, L. F.
Evans, Jas. L.	Thum, Ernest

HUNTERDON COUNTY

English, S. B.	Lane, E. W.
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MERCER COUNTY

Ackley, D. B.	Cottone, R. J.
Bellis, H. D.	D'Arcy, W. E.
Seeley, R. B.	Lavine, B. D.
Swern, Nathan	McCullough, J. H.
Adams, C. F.	Pessel, J. F.
Haggerty, D. L.	Proctor, F. E.
McGuire, J. J.	Schildkraut, J. N.
North, H. R.	Sista, C. R.
Vanneman, J. S.	Wilbur, W. L.

MIDDLESEX COUNTY

Spencer, I. T.
Mann, J. J.
Meinzer, M. S.
Gutman, B.
Weber, J. F.
Berkow, S. G.
Mark, Joseph
McKiernan, R.

MONMOUTH COUNTY

Herrmann, Wm. G.	Clayton, J. C.
Watkins, R. E.	

MORRIS COUNTY

Costello, Wm. F.	Carberry, E. T.
Teskey, Stanley	Gilbertson, R. L.
Teller, D. W.	Truax, A. J.
Krauss, Fletcher	Plume, C. A.
McMahon, B. C.	Thomas, Thos. S.

OCEAN COUNTY

Delegates	Alternates
Herbener, Eugene	Goldarein, A.
Bunnell, Fred.	Thompson, Theo.
Disbrow, D. M.	Dennison, Frank

PASSAIC COUNTY

McCoy, John	Gillson, J. T.
MacMillan, W.	Shapiro, L.
Carlisle, T. H.	Dingman, N.
Ash, P. W.	Vreeland, R. J.
Murn, Chas. J.	Hall, W. W.
Roemer, J.	Sutherland, W. W.

SALEM COUNTY

James, W. H.	Summerill, J. M.
Dunn, J. S.	Perry, T. L.
Green, D. W.	Hummel, L. C.

SOMERSET COUNTY

Renner, D. S.	Sferra, A. F. W.
Stillwell, A.	
Hegeman, R. F.	
Cooper, J. H.	
Lawton, A. W.	

SUSSEX COUNTY

Coleman, Jos. B.
Wilbur, F. P.
Morrison, F. H.

UNION COUNTY

Harrison, J. B.	Leggett, L. H.
Bowles, H. H.	Bensley, Maynard
Quinn, S. T.	Davis, S. H.
Hubbard, H. V.	Knauer, G.
Schlichter, C. H.	Casilli, A. R.
Krans, E. S.	Runnels, J. J.
Reiner, J.	Bloch, H.
Stein, E.	Blumberg, J.
Weigel, Elmer	Labow, J. J.
Morris, W. B.	Blythe, R. T.
Lance, E. W.	Drury, A. J.
Walsh, R. J.	Currie, J. W.
Ripps, M. L.	Johnson, N. H.
Brokaw, C. A.	Phelan, W.
Abel, H. E.	Carlin, E. J.

Delegates not elected until the April meeting

WARREN COUNTY

Varney, W. H.

MEETINGS OF THE COUNTY SOCIETIES

Atlantic County.—Meets second Friday evening monthly, except in June, July, August and September. Annual Meeting in November.

Bergen County.—Meets on second Tuesday each month, except July and August. Annual Meeting in January.

Burlington County.—Meets second Wednesday afternoon of January, March, May, September and November. Annual Meeting in November.

Camden County.—Meets first Tuesday in each month October to May inclusive, with an outing on second Tuesday in June. Annual Meeting in October.

Cape May County.—Meets on first Tuesday in April and October. Annual Meeting in October.

Cumberland County.—Meets on the second Tuesday of January, April, July and October. Annual Meeting in October.

Essex County.—Annual Meeting is the first Thursday in October. Other meetings on the second Thursday of each month, November to May, inclusive, on call of the President.

Gloucester County.—Regular meetings on the third Thursday of each month, October to June, inclusive. Annual Meeting in November. Annual Social Session in September.

Hudson County.—Meets first Tuesday evening of each month, October to May, inclusive. Annual Meeting in October.

Hunterdon County.—Meets on the fourth Tuesday of January, April, July and October, the latter being the Annual Meeting.

Mercer County.—Meets on the second Wednesday of each month, except July, August and September, at 8.30 p. m., in the Carteret Club

at Trenton. Annual Meeting in December. Annual Banquet in November.

Middlesex County.—Meets on the third Wednesday afternoon of each month, September to June inclusive. Annual Meeting in December.

Monmouth County.—Meets on the last Wednesday in each month from October to June inclusive. Annual Meeting on the Tuesday after the first Monday in December.

Morris County.—Meets on the second Tuesday in March, June, September and December. Annual Meeting in September. Special meetings (1-3 yearly) for additional scientific discussions arranged by Executive Committee.

Ocean County.—Meets in May and November as called by the Secretary. Annual Meeting in November.

Passaic County.—Meets on the second Thursday evening of each month, except June, July and August. Annual Meeting in October.

Salem County.—Meets on the second Wednesday in February, April, October and December. Annual Meeting in October. Social Meeting in May.

Somerset County.—Meets on the second Thursday afternoon in February, April, June, October and December. Annual Meeting in October.

Sussex County.—Annual Meeting on the second Tuesday in September; other meetings bi-monthly, September to May inclusive.

Union County.—Meets on the second Wednesday of January, April, July and October. Annual Meeting in October.

Warren County.—Meets on third Tuesday of January, April, July and October; the last named being the Annual Meeting.

MEMBERSHIP OF COUNTY MEDICAL SOCIETIES

Comprising the

MEDICAL SOCIETY OF NEW JERSEY

1934

ATLANTIC COUNTY (1)

Society organized June 7, 1880. Meets Friday of each month. Annual meeting in December.

President

Allman, David A., Atlantic City

Vice-President

Charlton, C. Coulter, Atlantic City

Secretary and Treasurer

Irvin, John S., Atlantic City

Reporter

Kilduffe, Robert A., Ventnor

Historian

Harley, H. L., Atlantic City

Censors

Davidson, Harold S., Atlantic City

Shivers, C. H. deT., Atlantic City

Quinn, Norman J., Atlantic City

Allman, David B., 104 St. Charles pl., Atl. City
 Andrews, Clarence L., 1616 Pacific av., Atl. City
 Axilrod, Maurice, 2620 Pacific av., Atlantic City
 Barbash, Samuel, 1902 Pacific av., Atlantic City
 Bartlett, Clara K., 4301 Atlantic av., Atlantic City
 Bassett, Norman H., 109 States av., Atlantic City
 Beir, I. R., Harverford Apts., Atlantic City
 Blampin, Winifred A., Galen Hill, Atlantic City
 Boysen, Theo. H., 100 Phila. st., Egg Harbor
 Bradley, Robert A., 1616 Pacific av., Atlantic City
 Brown, Carlisle J., 1015 S. Indiana av. A. C.
 Carrington, Wm. J., 905 Pacific av., Atlantic City
 Charlton, C. Coulter, 124 Illinois av., Atl. City
 Chew, Elisha C., 603 Pacific av., Atlantic City
 Clark, S. Worth, 152 S. North Carolina av., Atl. City
 Cleary, Joseph P., Minotola
 Conaway, Walt P., 1723 Pacific av., Atlantic City
 Cooney, Charles J., 121 S. Illinois av., Atlantic City
 Corson, Filbert R., 101 S. Indiana av., Atl. City
 Coward, Edwin H., 1423 Pacific av., Atlantic City
 Crane, Bernard, 306 Pacific av., Atlantic City
 *Cuskaden, A. D., 5902 Ventnor av., Ventnor
 Dalton, S. Eugene, 1616 Pacific av., Atlantic City
 Darnall, Wm. Edgar, 5 S. Morris av., Atlantic City
 Davidson, Harold S., 1616 Pacific av., Atlantic City
 Davis, W. Cole, 124 S. Illinois av., Atlantic City
 de Hellebranth, R. T., 104 S. Fr'nkft av., Ventnor
 *Doherty, Wm. John, 201 N. Main st., Pl'santville
 *Dunlap, Thomas G., 47 S. Virginia av., Atl. City
 Durham, Royal E., 114 S. Illinois av., Atlantic City
 Ewens, Arthur E., 3600 Pacific av., Atlantic City
 Fish, Clyde M., 7 W. Washington av., Pleasantville
 Fox, Wm. W., 101 S. Indiana av., Atlantic City
 Frank, Myrtle, 227 Philadelphia st., Egg Harbor
 Garrabrant, Clarence, 19 N. Penn'gton av., Atl. City
 Goldstein, Samuel, 36 W. Main st., Maye Land'g
 Gorson, Samuel F., 1005 Pacific av., Atlantic City
 Grier, Robt. M., 50 E. Washington av., Pl'santville
 Guion, Edward, P. O. Box 418, Atlantic City
 Halpern, Samuel, 504 Pacific av., Atlantic City
 Harley Halvor L., 101 S. Indiana av., Atlantic City
 Harvey, Edwin H., 20 N. Florida av., Atlantic City

Holoman, M. Browne, 3 N. Granville av., Margate
 Holt, Edw'd Z., Children's Seashore Home, Atl. City
 Hudson, W. J., 39 W. Wash'gton av., Pleasantville
 Hyman, Chas., 1616 Pacific av., Atlantic City
 Ireland, Milton S., 23 S. California av., Atl. City
 Irvin, John S., 1910 Pacific av., Atlantic City
 Jacobson, John J., 1616 Pacific av., Atlantic City
 James, Henry C., Mays Landing
 Johnson, V. Earl, 101 S. Indiana av., Atlantic City
 Kahn, Leo, 4806 Atlantic av., Ventnor
 Kaighn, Chas. B., 905 Pacific av., Atlantic City
 Kilduffe, Robert A., 5003 Atlantic av., Ventnor
 Krechmer, Abraham, 521 Pacific av., Atlantic City
 Leonard, Isaac E., 2842 Atlantic av., Atlantic City
 Lucas, Stanley L., 1600 Arctic av., Atlantic City
 Mackler, Louis, 705 Pacific av., Atlantic City
 Madden, Leland S., Pleasantville
 Magill, Marcus, 4116 Ventnor av., Atlantic City
 Major, Martin M., 1703 Pacific av., Atlantic City
 Marcus, Joseph H., 1148 Fifth av., N. Y. C., N.Y.
 Marshall, Jos. C., 1517 Pacific av., Atlantic City
 Martin, William, 117 S. Indiana av., Atlantic City
 Mason, James H., 3rd, 1616 Pacific av., Atl. City
 Massey, John F., 20 Newport av., Ventnor
 MeVay, James C., 2907 Pacific av., Atlantic City
 Miller, D. J. Milton, 7209 Ventnor av., Margate
 *Muellerschoen, Geo. J., 220 S. 16th st., Phila., Pa.
 Nickman, Harrison, 101 S. Indiana av., Atl. City
 Pennington, Geo. P., 12 S. Chelsea av., Atl. City
 Pennington, John, 101 S. Indiana av., Atl. City
 Pilkington, Albert, Amsterdam Apts., Atl. City
 Poland, Geo. A., 25 E. Washington av., Pl'santville
 Poland, Joseph, 1904 Pacific av., Atlantic City
 Quinn, Norman J., 3303 Pacific av., Atlantic City
 Read, Hilton S., Prof. Arts Bldg., Atlantic City
 Renner, Daniel C., 2703 Pacific av., Atlantic City
 *Richardson, Jas. J., New Martinville, W. Va.
 Rieck, Allan, 507 S. Main st., Pleasantville
 Roark, Jesse L., 454 Bellevue av., Hammonton
 Rodi, Louis M., 412 Bellevue av., Hammonton
 Roop, W. O., 101 S. Indiana av., Atlantic City
 Rosenberg, Louis, 1707 Pacific av., Atlantic City
 Rosenblatt, Sidney, 1904 Pacific av., Atlantic City
 Salasin, Samuel L., 511 Pacific av., Atlantic City
 Scanlan, D. Ward, 15 S. Illinois av., Atlantic City
 Schwarzkopf, Geo., 2900 Pacific av., Atlantic City
 Scott, Karl M., Prof. Arts Bldg., Atlantic City
 Senseman, Theodore, 3600 Pacific av., Atl. City
 Shenfeld, Isaac, 4806 Ventnor av., Ventnor
 Shimer, A. Burton, 606 Pacific av., Atlantic City
 Shivers, C. H. deT., 121 S. Illinois av., Atl. City
 Silvers, Homer I., 16 S. Suffolk av., Ventnor
 Sinkinson, Chas. D., Jr., 1616 Pacific av., Atl. City
 Smith, Andrew M., 344 Philadelphia st., Egg H'rb'r
 Speer, John U., N. Y. & Sunny av., Somers Point
 Stamps, G. Ruffin, 214 E. Verona av., Pleasantville
 Stern, Samuel, 2815 Pacific av., Atlantic City
 Stevenson, A. M., 7506 Ventnor av., Ventnor
 Stewart, Walter B., 8 N. Tallahassee av., Atl. City
 *Stewart, W. Blair, N. Car. & Pacific av., Atl. City
 Subin, Harry, 1616 Pacific av., Atlantic City
 Surran, Carl A., Prof. Arts Bldg., Atlantic City

ATLANTIC COUNTY—Continued

Timberlake, Baxter H., 1616 Pacific av., Atl. City
 Townsend, Mary E., 5 S. Penn. av., Atlantic City
 Uzzell, Edward F., 2703 Pacific av., Atlantic City
 Walker, Levi M., 151 S. Penn. av., Atlantic City
 Wescott, Wm. C., Delaware & Pacific avs., Atl. City
 Wilson, Lawrence A., 114 N. Shore rd., Absecon
 Woodburn, J. Hudson, 39 W. Wash. av., Pl's ntv'le
 Wright, Elizabeth, 138 S. Penn. av., Atlantic City

Honorary Members

Lawrence, Henry R., Atlantic City
 Gehring, Gustave P., San Diego, Calif.
 Reik, Henry O., Vermont Apts., Atlantic City
 Reynolds, Walter, Atlantic City
 Souder, Lewis R., 5 S. Victoria av., Ventnor

Resigned

Gehring, Gustave P., resigned as Active Member
 and was elected an Honorary Member.

Transferred

Chesler, Morris, to Delaware Society
 Read, Hilton S., from Philadelphia County, Pa.
 Siegel, Alvin E., to Macon Med. Soc., Bibb Co., Ga.
 Wright, Eliz. T., received from Middlesex Co.,

Number of active members and basis of representation, 107, March 15, 1934.

*Deceased.

BERGEN COUNTY (2)

Society organized February 28, 1854. Meets second Tuesday in each month except July and August. Annual meeting in January.

President

Liva, Arcangelo, Hackensack

Vice-President

Snedecor, Spencer T., Hackensack

Secretary

Knowles, George M., Ridgefield Park

Treasurer

Irwin, J. H., Englewood

Reporter

Littwin, Charles, Englewood

Censors

The President, Secretary and Treasurer

Adams, Flora, Hackensack
 Alexander, Samuel, Park Ridge
 Anderson, R. M., Hackensack
 Appold, George D., Bergenfield
 Baketel, S. H., Jersey City
 Balze, H. R., Leonia
 Barnes, William J., Englewood
 Bell, J. Finley, Englewood
 Berke, R. N., Hackensack
 Beyer, William, Jr., Englewood
 Black, L. W., Rutherford
 Blauvelt, Grace B., Ridgewood
 Blenkle, V. A., Teaneck
 Bono, J., Northvale
 Bookstaver, B. P., Teaneck
 Bregman, Alexander, Edgewater
 Brennan, A. T. V., Tenafly
 Brown, J. L., Grantwood
 Burbank, H. E., Lyndhurst
 Burnham, L., Englewood
 Burns, G. C. H., Tenafly
 Busicco, P. S., Englewood
 Byers, C. W., Rutherford
 Clarke, Edward W., West Englewood
 Clock, Ralph O., Pearl River, N. Y.
 Cloud, A. W., Englewood
 Cochrane, Cloland D., Closter
 Connor, Clarence A., Fort Lee
 Corn, David, Ridgefield Park
 Crandall, John K., Fort Lee
 Cropsey, Charles D., Rutherford
 Curtis, Donald, Hackensack
 D'Agostin, Henry, Cliffside
 Dayton, S. T., Englewood

Demarest, J. W., Hackensack
 Denig, R. D., Hackensack
 DeSanto, A. M., Hackensack
 Dezer, Chas. N., Jr., Englewood
 Dickson, J. D., Bogota
 Dilger, F. G., Cliffside
 Edwards, James B., Leonia
 Ellmers, B. J., New Milford
 Essertier, Edward P., Hackensack
 Farmer, Vincent, Hackensack
 Farr, W. J., 288 Griggs av., Teaneck
 Fielding, William M., Allendale
 Finke, George W., Hackensack
 Finke, John H. D., Hackensack
 Fisher, P. C., Ridgewood
 Fitzhugh, W. F., Ridgefield Park
 Fliegel, William, Maywood
 Fox, J. W., Hillsdale
 Franklin, S. I., Englewood
 Freeland, Frank, Hackensack
 Friedman, A. I., Little Ferry
 Garrett, Harry S., Park Ridge
 Gilady, Ralph, Hackensack
 Gittlesohn, I., Hackensack
 Gnasso, E. R., Fort Lee
 Goldberg, David, Westwood
 Greenfield, A. W., Hackensack
 Greenfield, W. J., Hackensack
 Grimes, Jesse R., Dumont
 Groff, P. A., Little Ferry
 Hallet, Frederick S., Hackensack
 Halpern, H., Englewood
 Harney, J. N., Teaneck
 Helff, J. R., Teaneck
 Heller, G. H., Englewood
 Hitzeman, L. A., 30 E. Passaic st., Maywood
 Horowitz, H. J., Morsemere
 Huff, Edmund N., Englewood
 Hull, D. B., Ridgewood
 Irwin, J. H., Englewood
 James, W. L., Englewood
 Johnson, G. L., Englewood
 Johnston, R. O., Harrington Park
 Jordan, W. L., Englewood
 Jukofsky, I. D., Ridgefield Park
 Kastler, F., Rutherford
 Keir, Floyd E., Englewood
 Kennedy, P. A., Englewood
 King, Chester A., Oradell
 Knapp, Richard E., Hackensack
 Knox, C. A., Ridgefield Park
 Knox, Harriet L., Hackensack
 Knowles, G. M., Ridgefield Park

BERGEN COUNTY—Continued

Kraissl, C., Englewood
 Lansing, T. B., Tenaflly
 Legato, S., Cliffside
 Levitas, Geo. M., Westwood
 Lewis, Alice B., Saddle River
 Littwin, Charles, Englewood
 Liva, Arcangelo, 5 Pangborn Pl., Hackensack
 Liva, P. F., Lyndhurst
 Lueddecke, Rowland E., E. Rutherford
 Lynch, M. M., Hackensack
 Lynn, J. V., Ridgefield
 Lyons, S. R., Englewood
 Macaulay, F. A., Teaneck
 Mackellar, James M., Tenaflly
 McCormack, F. C., Englewood
 McFeeley, P. R., Bogota
 McLane, D. B., Englewood
 Mader, A. I., Hackensack
 Markley, C. A., Teaneck
 Mears, W. G., Englewood
 Meyer, Edward H., Mahwah
 Meyer, H. M., 151 Central av., Maywood
 Morrison, B. G., Lyndhurst
 Mosher, H. L., Lyndhurst
 Muller, F. L., Carlstadt
 Mulligan, L. A., Leonia
 Nichol, L. C., Hackensack
 O'Brien, Paul, East Rutherford
 Payne, Joseph, Midland Park
 Phillips, Walter, Englewood
 Pitkin, George P., Bergenfield
 *Pratt, J. E., Dumont
 Proctor, James Wm., Englewood
 Protzman, T. B., Englewood
 Prout, Wm. B., West Englewood
 Reich, S. B., Oradell
 Reid, Erwin W., Garfield
 Richardson, Charles A., Closter
 Richie, E. W., Hackensack
 Riordon, J., Rutherford
 Ruch, Louis, Englewood
 Ryley, H. W., East Rutherford
 Sarla, Michael, Hackensack
 Schmidt, Walter W., Cliffside Park
 Sealey, H. J., Dumont
 Seymour, E. T., Tenaflly
 Smaine, E. C., Rutherford
 Snedecor, S. T., 50 Anderson st., Hackensack

Sosnow, L. M., Hillsdale
 Stuart, A. A. S., Ridgefield Park
 Swayze, A. A., Hackensack
 Teeter, John N., Englewood
 Tennis, E. N., Tenaflly
 Tether, Russell K., Closter
 Toal, Joseph, Ridgefield
 Trossbach, Herman, Bogota
 Tyson, Francis B., Leonia
 Vanderbeek, S. W., Englewood
 Vandersluis, H., Park Ridge
 Van Dyke, Joseph S., Palisade Park
 Vroom, W. L., Ridgewood
 Walsh, T. M., Hasbrouck Heights
 Ward, Alfred W., Demarest
 Ward, G. HaHrold, Englewood
 Warren, Charles B., Bergenfield
 Webb, Wilson D., Hackensack
 Werner, G. H., Englewood
 Whitman, L. B., Bergenfield
 Williams, W. C., Rutherford
 Wilson, H. B., Hackensack
 Witkoff, B., Woodridge
 Wolowitz, Harry B., Hackensack
 Worcester, George F., Englewood
 Wry, Orlin V., E. Rutherford
 Wurts, Margaret M., Englewood
 Yachnin, S., Lyndhurst

Honorary Members

Bell, J. Finley, Englewood
 Clock, Ralph C., Pearl River
 Lansing, T. B., Tenaflly
 Pratt, John E., Dumont
 Riordon, J., Rutherford
 Swayze, A. A., Hackensack

Associate Members

Burton-Opitz, R., Palisade
 Denison, W. C., Ridgewood
 Liddy, Frank P., Mahwah
 Payawall, J. L., Ramsey

Number of active members and basis of representation, 163, March 15, 1934.

*Deceased

BURLINGTON COUNTY (3)

Society organized May 19, 1829. Meets second Wednesday in January, March, May, September and November. Annual meeting in November.

President

Davis, Jacob M., Burlington

Vice-President

Hornberger, J. Howard, Roebling

Secretary and Treasurer

Tracy, George T., Beverly

Reporter

Shippo, Hammel P., Delanco

Censors

Anderson, R. D., Burlington
 Conroy, John S., Burlington
 Hunter, Edward R., Delanco

Anderson, Richard D., Burlington
 Bauer, Harry W., Palmyra

Busansky, Samuel T., New Lisbon
 Curtis, Howard C., Moorestown
 Darlington, Emlen P., New Lisbon
 Davis, E. Vernon, Vincentown
 Davis, Jacob M., Burlington
 Downs, Roscius I., Riverside
 *Dubell, John E., Columbus
 Fahrenbruch, F. D., Mt. Holly
 Geary, Russell D., Riverside
 Haines, Edgar J., Medford
 Haldeman, Robert E., Mt. Holly
 Hartman, Luther, Maple Shade
 Hogan, Carlton P., Burlington
 Hollingshead, Lyman B., Pemberton
 Hornberger, J. Howard, Roebling
 Hunter, Edward R., Delanco
 Imhoff, R. E., Moorestown
 Kowalski, Louis J., Burlington
 Kuder, Joseph M., Mt. Holly

BURLINGTON COUNTY—Continued

Le Favor, Dean H., Palmyra
 Longsdorf, Harold E., Mt. Holly
 Love, Elizabeth F., Moorestown
 Lucas, W. Fred, Burlington
 McDonnell, G. E., Mt. Holly
 *Marcy, Alexander, Jr., Riverton
 *Marks, S. J., Bordentown
 Mendenhall, Clinton D., Bordentown
 Metzger, Emma P. W., Riverside
 Meyer, Eugene A., Moorestown
 Mills, Charles S., Riverton
 Muldoon, Edward J., Florence
 Mulford, Ephraim R., Burlington
 Munro, Chas. A., Marlton
 Newcomb, Marcus W., Brown's Mills
 Remer, Daniel F., Mt. Holly
 Rodman, E. Warren, Beverly
 Rogers, Harry L., Riverton
 Schisler, Milton M., Florence
 Scott, Parry M., Beverly
 Shapiro, Chas. S., Maple Shade
 Shipps, Hammel P., Delanco
 Small, E. Lester, Medford
 Stokes, Joseph, Moorestown
 Stokes, Samuel Emlen, Moorestown
 Summey, Thomas J., Moorestown
 Thorne, Nathan, Moorestown

Tracy, George T., Beverly
 Ulmer, David H. B., Moorestown
 Viteri, Louis, Mt. Holly
 Wagner, J. G., Riverside
 Wilkinson, Geo. H., Moorestown
 Zwick, W. Walter, Riverside

Honorary Members

Stoddard, Francis J., Riverton

Resigned

Sutherland, W. S., Mt. Holly

Transfers

Kowalski, Louis J., received from Passaic Co.
 Lucas, Fred W., received from Hudson Co.

Non-Resident Associate Members

Borzell, F. F., Philadelphia, Pa.

Number of active members and basis of representation, 53.

100 per cent paid up March 15, 1934.

*Deceased.

CAMDEN COUNTY (4)

Society organized August 14, 1846. Meets first Tuesday of every month, October to May, inclusive, with an Outing on second Tuesday in June. Annual meeting in October.

President

Lee, Thomas B., Camden

Vice-President

Shafer, William F., Camden

Secretary

Gamon, Robert S., Camden

Treasurer

Lewis, T. K., Camden

Reporter

Del Duca, Vincent, Camden

Historian

Bentley, David F., Jr., Camden

Censors

Barrett, W. J., Camden
 Hummel, E. G., Camden
 Rogers, E. B., Collingswood
 Van Sciver, J. E. L., Camden

Anderson, William, 20 Kings Highway, Haddonfield
 Andrus, David L., 805 Cooper st., Camden
 Bailey, Wilson G., 512 Broadway, Camden
 Baker, Banks S., 3021 Mt. Ephraim av., Camden
 Baker, Maurice E., 1149 Kaighn av., Camden
 Barb, K. B., Kaighn & Princess avs., Camden
 Barnshaw, Harold M., 2626 Federal st., Camden
 Barrett, Wesley J., 517 Cooper st., Camden
 Becker, Fred C., 620 Benson st., Camden
 Beideman, Caspar M., 5 W. Maple av., Merchantville
 Bentley, David F., Jr., 406 Cooper st., Camden
 Brennan, Chas. L. S., 14 S. Broadway, Gloucester
 Brennan, John P., 306 Cooper st., Camden
 Brewer, David R., 536 Market st., Gloucester
 Brown, Stanley, Glen av., Laurel Springs
 Browning, Wm. J., 134 N. Centre st., Merchantville

Browning, W. Kempton, 120 N. Centre st., Merchantville
 Bush, Ralph K., 131 E. Park ave., Merchantville
 Buzby, B. Franklin, 414 Cooper st., Camden
 Capuano, Giacinto, 829 S. 4th st., Camden
 Carlander, C. R., 1972 Browning rd., Merchantville
 Casselman, Arthur J., 301 N. 2nd st., Camden
 Ciliberti, Frank J., 5th & Pine sts., Camden
 Clark, Ernest W., 209 Haddon av., Westmont
 Clement, Levina B., 124 Kings Hwy., W. Haddonfield
 Collier, Martin H., Camden Co. Hosp., Lakeland
 Conoly, J. Holbert, 300 Monmouth st., Gloucester
 Conoly, Lacy N., 601 Walnut st., Camden
 Crist, Walter A., 725 Collings av., W. Collingswood
 Crowley, Joseph W., 4005 Westfield av., Camden
 Davis, Albert B., 511 Cooper st., Camden
 Day, Grafton E., Frazier & N. J. ave., Collingswood
 Decker, Henry B., 527 Penn av., Camden
 Delbert, Irwin E., 618 Benson av., Camden
 Del Duca, Vincent, 406 Cooper st., Camden
 Driscoll, Chas. D., 213 Clements Br. rd., Barlington
 Dublin, George T., 211 N. 5th st., Camden
 Eaton, Arthur T., 201 4th av., Haddon Heights
 Ellis, Alexander, 513 Broadway, Camden
 Elwell, Alfred M., 407 Cooper st., Camden
 Ewing, Leslie H., Berlin
 Evans, Winborne D., 2704 Westfield av., Camden
 Eynon, Harold K., 579 Haddon av., Collingswood
 Farrell, Edgar A., 100 Kings Hwy., W. Haddonfield
 Favorite, Grant O., West Jersey Hosp., Camden
 Filkins, Cedric E., 418 W. Horse Pike, Audubon
 Fisher, Stella C., 4401 Westfield av., Camden
 Gamon, Robert S., 558 Newton av., Camden
 Geissler, Elmer E., 431 Monmouth st., Gloucester
 German, Geo. B., 429 Cooper st., Camden
 Glover, Lawrence L., 53 King's Hwy., Haddonfield
 Goldstein, Hyman I., 1425 Broadway, Camden
 Hadley, C. F., 201 W. Maple av., Merchantville
 Haines, Mabel S., 600 White Horse Pike, Audubon
 Haines, Wm. H., 217 Lafayette av., Audubon
 Hammett, Lee J., 760 N. 27th st., Camden
 Hays, Roy G., 567 Haddon av., Collingswood

CAMDEN COUNTY—Continued

- Hessert, Edmund C., Haddon & Col. avs., C't'gsw'd
 Hirst, E. Reed, 586 Federal st., Camden
 Hirst, Levi B., 586 Federal st., Camden
 Hollinshed, Beulah S., 600 Benson st., Camden
 Horner-Roger, Clara L., 721 Cooper st., Camden
 Howard, J. Edgar, 67 King's H'way, W. H'don'ld
 Hughes, Thos. E., 223 Cooper st., Camden
 Hummel, Ernest G., 414 Cooper st., Camden
 Hummel, Merwin L., 135 N. Centre st., M'ch'tville
 Hutcheson, Chas. R., 517 Cooper st., Camden
 Jack, H. Wesley, 920 Haddon av., Collingswood
 Jackson, Chas. H., 1250 Pk. Boulevard, Camden
 Jarrett, Harry, 925 Broadway, Camden
 Johnson, Chas. H., 1810 Broadway, Camden
 Kain, Thomas M., 403 Cooper st., Camden
 Kain, Wm. W., Cape May C't House, R.F.D.No.1
 Kinney, A. G., 917 Haddon av., Collingswood
 Kline, Oram R., 414 Cooper st., Camden
 Kutner, Chas., 1005 S. 5th st., Camden
 Larossa, Ernest A., 701 Cooper st., Camden
 Lee, Thomas B., 622 Cooper st., Camden
 Leavitt, John F., 522 N. 3rd st., Camden
 Lewis, Thos. K., 47 S. 27th st., Camden
 Lippincott, A. Haines, 406 Cooper st., Camden
 Lovett, Jos. C., Municipal Hospital, Camden
 Lyon, Leslie C., P. O. Box 63, Magnolia
 Macalister, Alexander, 626 Federal st., Camden
 MacAlpine, K. B., 533 Monmouth st. Gl't'r City
 McCarthy, Arthur M., 2772 Federal st., Camden
 McCollum, A. S., 218 Clements Br. rd., B'f'gton
 McConaghy, T. P., S.W.Cor. 10 & Cooper sts., C'm'n
 McDermott, Vincent, 511 State st., Camden
 McGlade, Thos. H., Camden Co. Hosp., Lakewood
 Madden, T. W., 16 Frazier av., Collingswood
 Mahaffey, Jesse L., 414 Cooper st., Camden
 Maldeis, A. M. K., 117 North 6th st., Camden
 Marcarian, Henry B., 904 Cooper st., Camden
 Marcy, John W., 117 E. Park av., Merchantville
 Meckay, Paul M., 405 Cooper st., Camden
 Mengel, Willard G., 400 Penn. av., Camden
 Meyer, George P., 410 Haddon av., Camden
 Moore, Wm. G., 1576 Mt. Ephraim av., Camden
 Nicholson, Jos. L., 205 Washington av., Haddon'ld
 Nowrey, Jos. E., Jr., 431 Vine st., Camden
 Osmun, Milton M., 611 Broadway, Camden
 Palm, Howard F., 614 N. 2nd st., Camden
 Phillips, Claude B., 891 Haddon av., Collingswood
 Pike, Charles E., 411 Newton st., Oaklyn
 Pinsky, Meyer M., 944 S. 5th st., Camden
 *Powell, William R., 702 Market st., Camden
 Pratt, Arthur C., 516 Cooper st., Camden
 Pratt, William H., 516 Cooper st., Camden
 Primas, Howard E., 772 Pine st., Camden
 Principato, Roberto, 402 Walnut st., Camden
 Raughley, Wm. C., Taunton av., Berlin
 Read, William T., 429 Cooper st., Camden
 Rhone, David S., 1202 Haddon av., Camden
 Richardson, Emma M., 577 Steven st., Camden
 Roberts, Jos. E., Jr., 403 Cooper st., Camden
 Rogers, Edw. B., 814 Haddon av., Collingswood
 Ross, Alex. S., 542 Cooper st., Camden
 Russell, Edward W., 801 Cooper st., Camden
 Ruttenberg, Max, 301 Cooper st., Camden
 Saunders, O. W., 1700 Broadway, Camden
 Scheffler, W. A. H., 511 Cooper st., Camden
 Schellenger, E. A. Y., 429 Cooper st., Camden
 Schrack, Helen F., 216 N. 5th st., Camden
 Schruggs, W. J., 3005 Kearsage rd., Fairview, Cam.
 Schwartz, Henry C., Atco
 Shafer, Alfred H., 405 Cooper st., Camden
 Shafer, C. P., Laurel rd., Laurel Springs
 Shafer, Fred'k Wm., 634 Penn. av., Camden
 Sharp, R. L., 726 Cooper st., Camden
 Shaw, Ernest B., 811 Collings av., W. Collingw'd
 Shemeley, Wm. C., Jr., 7 Haddon av., Camden
 Sherck, A. Lincoln, 2647 Westfield av., Camden
 Shipman, Jas. S., 542 Cooper st., Camden
 Shope, E. P., 956 Newton av., Camden
 Shull, E. C., 517 Cooper st., Camden
 Sieber, Isaac G., 204 Merchant st., Audubon
 Smith, James D., 701 N. 6th st., Camden
 Stein, Joseph M., 1004 Newton av., Camden
 Stimis, H. G., 300 Kaighn av., Camden
 Stone, A. L., 2838 Berkley st., Camden
 Stone, Frank P., 241 Kings Hwy., E. Haddonfield
 Summerill, Garnett, 330 Cooper st., Camden
 Thompson, P. H., 4612 Westfield av., Camden
 Van Sciver, John E. L., 106 Broadway, Camden
 Ward, Seth Allen, 325 Cooper st.
 Weiman, M. L., 803 Station av., Haddon Heights
 West, Gordon F., 527 Penn st., Camden
 Wheatland, M. F., 727 Walnut st., Camden
 Wiant, Herman E., 120 Windsor av., Haddonfield
 Wilson, I. E., 110 Chapel av., Merchantville
 Wilson, L. R., 3320 Federal st., Camden
 Wroblewski, B., 1166 Thurman st., *Camden

Honorary Members

- Nicholson, J. L., Haddonfield
 Leavitt, John F., Camden
 Marcy, John W., 117 E. Park av., Merchantville

Transferred

- Dublin, Geo. J., to Philadelphia Medical Society

Number of active members and basis of representation, 150.

100 per cent paid up March 15, 1934.

*Deceased.

CAPE MAY COUNTY (5)

Society organized December 18, 1883. Meets first Tuesday in April and October. Annual meeting in October.

President

Robbins, Warren D., Cape May City

Vice-President

Townsend, John B., Ocean City

Secretary

Way, Eugene, Sea Isle City

Treasurer

Tomlin, H. Hurlburt, Wildwood

Reporter

Way, Eugene, Sea Isle City

Censors

Gandy, C. M., Ocean View
 Hughes, Frank R., Cape May
 Ziegler, Oscar F., Wildwood

Crowe, Aldrich C., Ocean City
 Cryder, Millard, Cape May Court House
 Dandois, George F., Wildwood
 Darby, A. Eugene, Ocean City
 Freeland, A. J., Woodbine
 Gandy, Charles M., Ocean View
 Haines, W. P., Ocean City
 Hornstine, H. H., Wildwood
 Hughes, Frank R., Cape May

CAPE MAY COUNTY—Continued

Mace, Margaret, North Wildwood
 Monasson, Ida, Woodbine
 Pettit, Herschel, Ocean City
 Robbins, Warren D., Cape May
 Smith, Marcia V., Ocean City
 Tomlin, H. Hurlburt, Wildwood
 Way, Clarence W., Sea Isle City
 Way, Eugene, Sea Isle City
 Way, Julius, Cape May Court House
 Whiticar, John H., Ocean City

Ziegler, Oscar, Wildwood

Non-Resident Honorary Members

Gandy, Charles L., U. S. A.
 Gordon, Alfred, Philadelphia, Pa.
 Ingram, J. H., China
 Reik, Henry O., Atlantic City

Number of active members and basis of representation, 20, March 15, 1934.

CUMBERLAND COUNTY (6)

Society organized June 16, 1816. Meets second Tuesday of January, April, July and October. Annual meeting in October.

President

Simpkins, Ray, Bridgeton

Vice-President

Bennett, Samuel D., Millville

Secretary

Lyons, E. C., Bridgeton

Treasurer

Wilson, H. H., Bridgeton

Reporter

Corson, Elton S., Bridgeton

Censors

Gray, Charles H., Vineland
 Branin, Howard, Millville
 Sewall, Millard F., Bridgeton

Bacon, Mary, Bridgeton
 Baker, Hugh W., Vineland
 Bellak, Ellis R., Leesburg
 Bennett, Samuel D., Millville
 Bostwick, Delazon S., Bridgeton
 Branin, Howard, Millville
 Butcher, Charles, Heisleville
 Clippinger, R. D., Vineland
 Cornwell, Alfred W., Bridgeton
 Corson, Elton S., Bridgeton
 Cunningham, Charles, Jr., Vineland
 Davies, George A., Elmer
 Day, Samuel Thomas, Port Norris
 Elmer, Matthew K., Bridgeton
 Garrison, Walter Sherman, Cedarville
 Gray, Charles M., Vineland
 Harris, Allen, Greenwich
 Kauffman, Louis J., Millville
 Knowles, James S., Millville
 Lloyd, Reba (Kumpf), Bridgeton
 Loden, Horace B., Bridgeton
 Loper, John G., Bridgeton
 Lore, Harry E., Bridgeton

Lummis, C. Percy, Bridgeton
 Lyon, Earl C., Bridgeton
 Mayhew, Charles H., Millville
 Miller, H. Garrett, Millville
 Myatt, Leslie E., Bridgeton
 Neal, Charles B., Millville
 Oliver, David H., Bridgeton
 Pino, Anthony, Bridgeton
 Ramsey, F. Muriel, Millville
 Reeves, J. Franklin, Bridgeton
 Sewall, Millard F., Bridgeton
 Sharp, Charles E., Port Norris
 Sheppard, Frank R., Millville
 Simpkins, Raymond, Bridgeton
 Thalheimer, E. J., Vineland
 Thomas, George N., Vineland
 Van Deusen, Edwin H., Vineland
 Wainwright, F. P., Bridgeton
 Walker, Ada Harris, Vineland
 Walker, H. Burton, Vineland
 Ware, Carl N., Shiloh
 Ware, Francis V., Millville
 Weithaase, Helen E., Vineland
 Whaland, Berta, Bridgeton
 Wilson, Charles W., Vineland
 Wilson, Herbert H., Bridgeton
 Winslow, John H., Vineland
 Woodruff, Dare, Vineland

Non-Resident Associate Members

*Ashton, W. E., 2011 Walnut st., Philadelphia, Pa.
 Barton, J. M., 1314 Spruce st., Philadelphia, Pa.
 *De Costa, J. C., 2045 Walnut st., Philadelphia, Pa.
 Hirst, B. C., 1821 Spruce st., Philadelphia, Pa.
 *Keen, W. W., 1729 Chestnut st., Philadelphia, Pa.
 Noble, Charles P., 1509 Locust st., Phila., Pa.
 Reisman, David, 162 Spruce st., Philadelphia, Pa.

Number of active members and basis of representation, 51.

100 per cent paid up March 15, 1934.

*Deceased.

ESSEX COUNTY (7)

Society organized June 4, 1816. Meets second Thursday, at call of Council, from October to May. Annual meeting in October.

President

Sprague, Edward W., Newark

Vice-President

Condon, John F., Newark

Secretary

Pinneo, Frank W., Newark

Treasurer

Rogers, Robert H., Newark

Reporter

Wood, Earl LeRoy, Newark

ESSEX COUNTY—Continued

Councilors

Edgar A. Ill, 1934
 John D. Moore, 1934
 B. B. Ranson, Jr., 1934
 James T. Hanan, 1935
 H. Roy Van Ness, 1934
 David A. Kraker, 1935
 Alfred Stahl, 1935
 A. Charles Zehnder, 1935
 The E-President (ex-officio)

Abrams, A. B., 668 Clinton av., Newark
 Adams, John K., 3 Prospect st., E. Orange
 Adelman, Benj. B., 190 Clinton av., Newark
 Albano, Joseph, 535 N. 7th st., Newark
 Albee, Geo. C., 219 S. Orange av., S. Orange
 Alexander, Wallace G., 48 Webster pl., Orange
 Allan, James S., 49 Prospect st., E. Orange
 Allen, G. Herbert, 181 Roseville av., Newark
 Alling, Frederick A., 15 Washington st., Newark
 Ambrose, Anthony, 71 Congress st., Newark
 Angelillo, Marc C., 333 Clifton av., Newark
 Angell, Emmett D., 4 Sloan st., W. Orange
 Antonius, N. A., 27 W. Market st., Newark
 Areson, Wm. H., 153 B'vue av., Upper Montclair
 Asher, Maurice, 186 Clinton av., Newark
 Aszody, Paul, 340 Waverly av., Newark
 Avidan, Maurice S., 30 Stratford pl., Newark
 Bachmann, Wm., 87 Hillcrest ter., East Orange
 Bagg, Linus W., 31 Lincoln Park, Newark
 Baird, T. M., 124 Grand pl., Arlington
 Baker, Charles F., 198 Clinton av., Newark
 Baker, Maclyn, 638 Stuyvesant av., Irvington
 Baldwin, Samuel H., 626 Clinton av., Newark
 Balson, Z. D. E., 884 S. 14th st., Newark
 Banks, Winfred D., 6 N. Munn av., East Orange
 Barkhorn, Charles W., 223 Roseville av., Newark
 Barkhorn, Henry C., 45 Johnson av., Newark
 Barrett, Jos. F., 230 Parker av., Maplewood
 Baum, Felix, 31 Lincoln Park, Newark
 Baum, Samuel, 10 Osborne ter., Newark
 Becker, Fred W., 14 Clinton pl., Newark
 Becket, George C., 350 Springdale av., E. Orange
 Beling, Chris. C., 109 Clinton av., Newark
 Bell, Thomas, 340 Belmont av., Newark
 Benedict, A. C., 121 Irvington av., South Orange
 Bengelsdorf, A., 29 Clinton pl., Newark
 Bennett, W. F., Essex Co. Sanatorium, Verona
 Beradinelli, C. G., 92 Eighth av., Newark
 Berg, S., 530 Central av., Newark
 Berger, W. A., 268 N. 7th st., Newark
 Bergman, M. W., 825 So. 10th st., Newark
 Berman, H. Robert, 286 Roseville av., Newark
 Beyer, O. J., 42 Laurel av., Irvington
 Bianchi, Angelo R., 104 7th av., Newark
 Bien, Frank A., 999 Clinton av., Irvington
 Bigelow, N. S., 117 Irvington av., South Orange
 Bingham, Arthur W., 144 Harrison st., E. Orange
 Birdsall, Clarence, 3 Smal av., Caldwell
 Bissett, John V., 29 Hawthorne av., E. Orange
 Blackburne, George, 490 Central av., Newark
 Blanchard, Kenneth, 25 S. Munn av., E. Orange
 Bleick, Theo. E., 61 Van Ness pl., Newark
 Bleick, William D., 583 Prospect av., Maplewood
 Bleier, Louis, 88 Clinton av., Newark
 Block, Marcus T., 177 Bloomfield av., Newark
 Bonomo, M. J., 477 Springfield av., Newark
 Bostwick, Wallace R., 56 Church st., Montclair
 Brackett, Elizabeth R., 349 Franklin av., Nutley
 Bradford, Stella S., 16 Seymour av., Montclair
 Bradshaw, John H., 27 High st., Orange
 Brakeley, Elizabeth, 21 Trinity pl., Montclair
 Braun, Gus A., 391 Bergen st., Newark
 Breitstadt, Chas. A., 168 Delevan av., Newark
 Brien, Wm. M., 449 Main st., Orange
 Briggs, H., 16 Undercliff ter., W. Orange
 Brim, Anne J. S., 83 Lincoln Park, Newark
 Broadnax, Mary E., 83 Lincoln Park, Newark
 Brodtkin, Eva T., 365 Osborn ter., Newark
 Brodtkin, H. A., 365 Osborne ter., Newark
 Brothers, James H., 1175 Raymond blvd., Newark
 Brotman, Morton M., 90 Avon av., Newark
 Brown, Chester R., 22 Midland av., Arlington
 Brown, Chester T., Prudential Ins. Co., Newark
 Brown, E. V., 585 Kearny av., Arlington
 Brown, Lewis W., 15 Fulton st., Newark
 Brown, Richard J., 105 Ridgewood rd., S. Orange
 Buckley, J. L., 684 Franklin av., Nutley
 *Buerman, Wm., 9 Lincoln Park, Newark
 Bull, Louis M., 92 Heller Parkway, Newark
 Bull, Robert I., 531 W. Market st., Newark
 Bull, W. J., 98 Park st., Montclair
 Bumsted, Clarence, 235 Grafton av., Newark
 Burke, Stephen E., 212 First av., Newark
 Burne, John J., 17 Gould av., Newark
 Burns, Edward L., 269 Broad st., Newark
 Burbeau, Wm. P., 144 Harrison st., East Orange
 Busch, Herman, 38 Johnson av., Newark
 Bush, Archer C., 40 Union av., Montclair
 Butler, Eustace C., 249 Bloomfield av., Caldwell
 Buvinger, Chas. W., 50 Washington st., E. Orange
 Cacciarelli, Robt. A., 517 Roseville av., Newark
 Cahill, L. A., 353 Lafayette st., Newark
 Caldwell, J. A., 45 S. Mountain av., Montclair
 Calvert, Wm. C., 220 Central av., Orange
 Camche, L. J., 250 Renner av., Newark
 Cameron, Edwin A., 186 S. Burnett st., E. Orange
 Campbell, H. B., 21 Court st., Newark
 Campbell, Wm., 144 Harrison st., East Orange
 Carbone, Francis R., 157 Hunterdon st., Newark
 Cardwell, E. P., 15 Fulton st., Newark
 Carman, Fletcher F., 31 Lincoln Park, Newark
 Carrigan, Francis P., 288 Franklin av., Nutley
 Caruso, Rocco J., 222 Mt. Prospect av., Newark
 Casale, John B., 496 Highland av., Newark
 Cater, Douglas A., 55 Harrison st., East Orange
 Cerone, Daniel M., 398 N. 11th st., Newark
 Chamberlain, Aims R., 30 Lenox pl., Maplewood
 Chapman, R. W., 835 Bergen st., Newark
 Chenitz, Wm., 530 Orange st., Newark
 Cherashore, H., 363 Centre st., Nutley
 Chiger, Alexander S., 621 High st., Newark
 Chisholm, Gibbs, 14 Boston st., Newark
 Chmelnik, A. G., 299 Clinton av., Newark
 Clark, J. Henry, 108 Orange road, Montclair
 Clarken, Jos. A., 43 Lincoln Park, Newark
 Coburn, John W., 111 N. Oraton Pkwy., E. Orange
 Coffin, Henry, 433 Mt. Prospect av., Newark
 Coghlan, Jasper, 17 Academy st., Newark
 Cohen, Maurice, 106 Valley rd., Montclair
 Cohen, Meyer J., 32 Runyon st., Newark
 Cohen, Sidney L., 20 Avon av., Newark
 Cohn, G. M., 748 S. 10th st., Newark
 Cohn, Herman, 393 Clinton av., Newark
 Cohn, Royal M., 740 Clinton av., Newark
 Colmer, Meyer J., 407 Lyons av., Newark
 Colsh, LeRoy L., 612 Ridgewood rd., Maplewood
 Comando, Harry N., 31 Lincoln Park, Newark
 Condon, John F., 686 Mt. Prospect av., Newark
 Conlon, Philip, 25 James st., Newark
 Connamacher, H. S., 671 Springfield av., Newark
 Connolly, John J., 212 Market st., Newark
 Connolly, Richard N., City Hospital, Newark
 Cook, H. F., 31 Lincoln Park, Newark

ESSEX COUNTY—Continued

- Cooke, Wm. H., 303 Main st., East Orange
 Cooperman, Wm., 647 Market st., Newark
 Cordasco, P., 48 Glen Ridge av., Montclair
 Corrigan, Geo. F., 344 Lafayette st., Newark
 Corwin, Theo. W., 671 Broad st., Newark
 Coughlan, Ella A., 10 Oakwood av., Orange
 Coughlin, Frank J., 594 Kearny av., Arlington
 Cox, William W., 27 S. Fullerton av., Montclair
 Crane, Chas. G., 78 Farley av., Newark
 Craster, Chas. V., 381 Parker st., Newark
 Crawford, Georgiana U., 28 Carnegie av., O. O.
 Crecca, Wm. D., 111 Park av., Newark
 Crossfield, H. C., 491 S. Orange av., South Orange
 Crystell, E. H., Hillside av., Nutley
 Curtis, Elbert A., 65 Central av., Newark
 Dane, Chas., 61 Scotland rd., South Orange
 Dane, John, 61 Scotland rd., South Orange
 Danzis, Max, 31 Lincoln Park, Newark
 Darden, Walter T., 149 W. Kinney st., Newark
 Davenport, Peter B., 764 S. Orange av., Newark
 Davidson, Henry A., 31 Lincoln Park, Newark
 Davidson, Louis L., 31 Lincoln Park, Newark
 Davies, George W., 15 Fairview av., Verona
 DeFronzo, Morando, 180 Fairmount av., Newark
 Del Deo, Nicholas V., 47½ State st., Newark
 Del Guercio, O., 342 Clifton av., Newark
 Demarest, L. M., 228 S. Orange av., South Orange
 Denes, O. J., 402 Centre av., Nutley
 Deriveaux, John A., 103 Clinton av., Newark
 De Vausney, Winfield S., 50 James st., Newark
 De Vincentis, Henry, 285 Henry st., Orange
 Devlin, Frank, 617 Broadway, Newark
 Devlin, Hugh J., 72 Thomas st., Newark
 Dias, Joseph L., 17 Lombardy st., Newark
 Dieffenbach, Rich'd H., 570 Mt. Prospect av., Newark
 Dinge, Ferdinand Chas., 67 S. Munn av., E. Or.
 Dodd, Edward L., 151 Forest st., Belleville
 Donahue, Wm. J., 173 Roseville av., Newark
 Donchi, S. M., 400 Belmont av., Newark
 Donnelly, Robt. J., 208 Market st., Newark
 Doremus, Widmer E., 375 Mt. Prospect av., Newark
 Dorn, Elliot I., 267 Vassar av., Newark
 Dowd, Ambrose F., 239 Broadway, Newark
 Dragonetti, E. N., 177 Clifton av., Newark
 Dreskin, J. L., 172 Lyons av., Newark
 DuBois, M. G., 769 High st., Newark
 Dulin, Everett K., 144 Harrison st., E. Orange
 Dunn, Theodore B., 194 Broad st., Bloomfield
 Eagleton, Wells P., 15 Lombardy st., Newark
 Ebenfeld, S. W., 344 High st., Newark
 Echikson, Joseph I., 845 S. 12th st., Newark
 Edelen, James J., 280 S. Clinton st., E. Orange
 Eigen, Louis A., 358 Gregory av., W. Orange
 Eln, Wm. B., 31 Lincoln Park, Newark
 Eisenberg, David S., 633 Sanford av., Newark
 Ellis, Moury I., 177 S. Clinton st., East Orange
 Emerson, Linn, 310 Main st., Orange
 Emmer, S. Wolfe, 234 Clinton av., Newark
 English, James R., 51 Cypress st., Newark
 English, John T., 681 Stuyvesant av., Irvington
 Epier, Don A., 45 Hillside av., Newark
 Epstein, Henry B., 31 Lincoln Park, Newark
 Erler, Eugene W., 119 N. 5th st., Newark
 Ervin, Millard B., 572 Prospect st., Maplewood
 Etheridge, Charles E., 479 Prospect st., E. Orange
 Evans, Charles H., 144 Harrison st., E. Orange
 Ewing, Harvey M., 31 Lincoln Park, Newark
 Fager, Rudolph O., 98 Broad st., Bloomfield
 Failing, Brayton E., 31 Lincoln Park, Newark
 Fanburg, Sol. J., 31 Lincoln Park, Newark
 Farden, Jos. L., 342 Roseville av., Newark
 Farr, Irving L., 214 Walnut st., Montclair
 Fasano, G., 194 S. 7th st., Newark
 Faughnan, Rose, 97 High st., Passaic
 Fechner, Julius, 138 W. Kinney st., Newark
 Fein, Bernard, 585 Elizabeth av., Newark
 Fendrick, Edward, 138 Park pl., Irvington
 Ferguson, W. E., 1175 Raymond blvd., Newark
 Fern, S. S., 122 Elizabeth av., Newark
 Fewsmith, Jos. L., 120 Second av., Newark
 Fine, Moses J., 175 Clinton av., Newark
 Finesilver, Edward M., 31 Lincoln Park, Newark
 Fink, Irving E., 129 Lyons av., Newark
 Finkel, Joshua, 368 Clinton av., Newark
 Finkelstein, A. S., 174 Johnson av., Newark
 Finkler, Rita S., 99 Lyons av., Newark
 Fischman, H. H., 34 Sterling st., Newark
 Fitzpatrick, Edward F., 574 Warren st., Newark
 Flower, M. A., 39 Lincoln Park, Newark
 Flynn, E. A., 161 Washington av., Belleville
 Forsythe, Kenneth C., 530 Summer av., Newark
 Fort, J. Irving, 306 Roseville av., Newark
 Foster, Herbert W., 2 Erwin Park, Montclair
 Foster, W. S., 233 Mt. Prospect av., Newark
 Fowler, Royal H., 744 Broad st., Newark
 Frederick, Gus H., 349 Camden st., Newark
 Freeman, George C., 1 Lenox pl., Maplewood
 Freeman, Richard D., 103 Scotland Rd., S. Orange
 Friedman, Hyman, 1096 Sanford av., Irvington
 Friedman, Milton, Beth Israel Hosp., Newark
 Friedrich, Adam H., 424 Lafayette st., Newark
 Freinkel, Jacob, 2 Hillside av., Newark
 Froelich, J. C., 74 Ingraham pl., Newark
 Furman, Benj. A., 31 Roseville av., Newark
 Furst, Nathan J., 190 Johnson av., Newark
 Ganley, Arthur J., 390 Park av., East Orange
 Ganot, F. I., 639 Ridge st., Newark
 Gantz, O. E., 215 N. Grove st., East Orange
 Gardam, J. W., 16 Longfellow av., Newark
 Gauch, Wm., 177 Ellwood av., Newark
 Gelber, L. J., Lincoln Park, Newark
 Gennell, Ernest, 298 Parker st., Newark
 George, M. E. W., 805 Broadway, Newark
 Gershenfeld, David B., 20 Hillside av., Newark
 Gifford, W. Royal, 247 Park av., East Orange
 Glass, Oscar, 838 S. 12th st., Newark
 Glass, William H., 144 Harrison st., East Orange
 Godfrey, Allan O., 220 Roseville av., Newark
 Goeller, J. D., 1165 W. Clinton av., Irvington
 Goffman, Emanuel, 81 Valley rd., Montclair
 Goldberg, H. H., 814 S. 10th st., Newark
 Goldberg, Louis E., 31 Lincoln Park, Newark
 Goldberg, Samuel A., 46 Farley av., Newark
 Goldberg, Samuel M., 353 Wash. av., Belleville
 Goldstein, Henry Z., 190 Clinton av., Newark
 Goldberg, Samuel M., 353 Wash. av., Belleville
 Goldstein, W. H., 632 Belgrove dr., Arlington
 Goodfellow, G. P., 526 Park av., East Orange
 Goodwin, Wm. M., 75 Congress st., Newark
 Gordon, A. J., 273 Roseville av., Newark
 Grady, Wm. F., 42 N. Fullerton av., Montclair
 Grant, William F., 162 Roseville av., Newark
 Gray, John W., 142 Clinton av., Newark
 Greenberg, Samuel, 46 Johnson av., Newark
 Gregorius, Ralph F., 120 Irvington av., S. Or.
 Gregory, Mildred G., 21 Roseville av., Newark
 Greifinger, Marcus H., 22 Vassar av., Newark
 Griffith, Roy, 909 Broad st., Newark
 *Griffiths, Chauncey B., 105 Park av., E. Orange
 Grossblatt, Philip, 70 Baldwin av., Newark
 Guthrie, W. G., 300 Summer av., Newark
 Gutkowski, W. T., 104 Grove ter., Irvington
 Hagerty, John F., 212 W. Market st., Newark
 Hagney, Fred W., 669 Elizabeth av., Newark

ESSEX COUNTY—Continued

- Hahn, Katherine B., 272 Thornden st., S. Orange
Hahn, William, 272 Thornden st., S. Orange
Halprin, Harry, 8 Washburn pl., Caldwell
Halsey, Levi W., 61 Church st., Montclair
Hanan, Jas. T., 11 The Crescent, Montclair
Harden, Albert S., 540 Warren st., Newark
Harhen, Geo. E., 22 Brookside av., Caldwell
Hart, H. M., 300 Mt. Prospect av., Newark
Harvey, Thos. W., 59 Main st., Orange
Harvey, Thos. W., Jr., 59 Main st., Orange
Hasney, Fredrick A., 292 Main st., W. Orange
Hauck, Lydia B., 644 Stuyvesant av., Irvington
Hauck, Wm. H., 644 Stuyvesant av., Irvington
Haussling, Francis R., 661 High st., Newark
Hawkes, E. Zeh, 84 Washington st., Newark
Hawkes, Stuart Zeh, 84 Washington st., Newark
Heath, Louanna, 20 Fairmount av., Newark
Heineken, T. S., 17 Park pl., Bloomfield
Heller, Nathan B., 31 Lincoln Park, Newark
Henle, C. B., 671 Springfield av., Newark
Herman, John H., 197 S. Centre st., Orange
Herold, Harvey T., 850 S. 13th st., Newark
Herold, Herman C. H., 1115 Broad st., Newark
Hersh, David H., 658 Springfield av., Newark
Hewson, James S., 163 Myrtle av., Millburn
Hexamer, Fred, 50 Lyons av., Newark
Heyman, Arthur, 79 Baldwin av., Newark
Hicks, William H., 46 Milford av., Newark
Hill, Robert H., 332 Park av., Newark
Hilliard, Ruth, 220 Sussex av., Newark
Hilton, C. O., 598 N. 5th st., Newark
Hobart, Richard T., 191 Bellev'le av., U. Montcl'r
Hoeler, Wm. F., 808 S. 11th st., Newark
Holden, Edgar, Jr., 217 Broadway, Newark
Holland, Geo. A., 364 Clinton av., Newark
Holler, Henry G., 234 Montclair av., Newark
Holmes, Geo. J., 17 Elizabeth av., Newark
Horn, Max, 94 Lyons av., Newark
Horsford, Fred C., 305 Broadway, Newark
Hosp, Paul H., 842 S. 12th st., Newark
Houck, W. J., 207 Mt. Prospect av., Newark
Hubbard, Fayette E., 65 Church st., Montclair
Hubbard, Robert Y., 58 Myrtle av., Irvington
Huber, Wm. H., 15 Salem st., Newark
Huberman, John, 853 S. 12th st., Newark
Hughes, Lee W., 965 Broad st., Newark
Hulet, Albert G., 20 Hawthorne av., E. Orange
Humphries, Robert E., 637 Central av., E. Orange
Hurff, Jos. W., 86 Washington st., Newark
Husserl, Siegfried, 777 Clinton av., Newark
Ignatoff, M. L., 493 Central av., Newark
Ill, Carl H., 188 Clinton av., Newark
Ill, Charles L., 188 Clinton av., Newark
Ill, Edgar A., 1002 Broad st., Newark
Ill, Edmund W., 188 Clinton av., Newark
Ill, Edward J., 1004 Broad st., Newark
Ill, Herbert M., 188 Clinton av., Newark
Irwin, Jas. R., 330 Washington av., Belleville
Jackson, Albert F., 225 Hillside av., Nutley
Jackson, E. C., 98 Washington st., E. Orange
James, Bart M., 31 Lincoln Park, Newark
Janifer, Clarence S., 208 Parker st., Newark
Japhe, Nathaniel M., 190 Clinton av., Newark
Jaso, James V., 274 Littleton av., Newark
Jedel, Meyer, 125 Fourth st., Newark
Jessurun, S. H., 613 High st., Newark
Jones, E. C., 75 Midland av., Montclair
Jonitz, Robert, 157 S. Grove st., E. Orange
Judge, John F., 1009 S. Orange av., Newark
Just, Francis, 564 High st., Newark
Kahrs, Grace M., 375 Mt. Prospect av., Newark
Kaufhold, Frank, 41 Leslie st., Newark
Kaufman, Jerome G., 299 Clinton av., Newark
Kaufman, M. J., 103 Lyons av., Newark
Kavanaugh, D. E., 252 Washington av., Belleville
Kearney, Edward P., 26 Forest st., Montclair
Keim, Wm. F., 25 Roseville av., Newark
Keller, Sidney C., 31 Lincoln Park, Newark
Kennedy, Wm. M., Es. Co. Sanatorium, Verona
Kenney, J. A., 132 W. Kinney st., Newark
Kern, E. Clarence, 45 Park st., Montclair
Kerns, Francis J., 556 Warren st., Newark
Kessler, H. H., 31 Lincoln Park, Newark
Kessler, Henry B., 666 Clinton av., Newark
Kirkby, Cyril S., 98 Broad st., Bloomfield
Kirkman, Leroy G., 176 Roseville av., Newark
Kirkwood, Allan S., 53 Union st., Montclair
Klein, Edward C., Jr., 209 Littleton av., Newark
*Klein, Ignatz, 471 Springfield av., Newark
Klenk, J. P., 328 Belleville av., Bloomfield
Kolodin, A., 147 Franklin st., Bloomfield
Kraemer, Manfred, 186 Clinton av., Newark
Kraker, David A., 31 Lincoln Park, Newark
Krichbaum, Carroll E., 63 Myrtle av., Montclair
Krone, W. F., 31 Lincoln Park, Newark
Kruger, William, 31 Lincoln Park, Newark
Kummel, M., 315 Central av., E. Newark
Lafferty, Elton B., 328 Myrtle av., Irvington
Landesman, Wm., 138 Kearny av., Kearny
Lane, Austin W., 98 Prospect st., East Orange
Lane, Frank B., 53 Woodland av., East Orange
Lawrence, Minnie J., 83 Second av., Newark
LeBel, Louis J. B., 165 Grant av., Nutley
Lee, Stephen G., 55 Halsted st., East Orange
Leonardis, Jas. V., 94 Jefferson st., Newark
Levin, Joseph, 831 S. 13th st., Newark
Levin, M. L., 326 Avon av., Newark
Levinson, L. J., 190 Clinton av., Newark
Levy, Julius, 66 Baldwin av., Newark
Lewis, Geo. R., 458 Washington av., Belleville
Leyenberger, S. B., 319 Mt. Prospect av., Newark
Lippard, Alvin T., 682 Stuyvesant av., Irvington
Livingston, Paul, 299 Main st., East Orange
Loder, Joseph S., 924 S. 17th st., Newark
Loeser, Lewis Henry, 31 Lincoln Park, Newark
Long, Herbert W., 102 Jefferson st., Newark
Lottridge, Dorothy, 43 S. Maple av., E. Orange
Lovell, John F., 1011 Clinton av., Irvington
Lowenstein, H. A., 96 Milford av., Newark
Lowrey, Jas. H., 79 Congress st., Newark
Lowy, Otto, 190 Clinton av., Newark
Luban, Benjamin, 730 High st., Newark
Lundblad, Walt. E., 75 Prospect st., E. Orange
Lynch, A. E. O., 257 Orange rd., Montclair
Lyon, Archibald, 115 Ridge rd., Arlington
Lyons, James V., 333 Park st., Orange
*McArthur, Charles, 5 Elm st., South Orange
MacArthur, Clymont, 219 Roseville av., Newark
Macdonald, W. S., 56 Church st., Montclair
Maciejewski, A. S., 212 Van Buren st., Newark
McBride, Hesser G., 1072 S. Orange av., Newark
McCabe, Thos. S., 913 Broad st., Newark
McCauley, Francis J., 31 Lincoln Park, Newark
McCormick, Jas. E., 322 Clinton av., Newark
McCullough, W. A., Essex Co. Hosp., Cedar Gr.
McCroskery, Jas. H., 396 N. Arlington av., E. Or.
McEwen, Floy, 299 Broadway, Newark
McKim, William F., 1044 S. Orange av., Newark
McLellan, Geo. A., 19 Hawthorne av., E. Orange
MacPherson, Elwood H., 12 Rawley pl., Millburn
McVay, Edward A., 234 Lafayette st., Newark
Mahood, H. L., 86 Durand rd., Maplewood
Malavazos, Antonio, 635 High st., Newark
Maliniak, Jacques W., 31 Lincoln Park, Newark

ESSEX COUNTY—Continued

- Mamlet, Alfred M., 16 Johnson av., Newark
 Mancusi-Ungaro, E., 270 Mt. Prospect av., N'w'k
 Mancusi-Ungaro, L., 156 Mt. Prospect av., N'w'k
 Marks, Edward G., 655 Kearny av., Arlington
 Marquis, Dean W., 132 N. Arlington av., E. Orange
 Marquis, W. James, 198 Clinton av., Newark
 Martin, Wm. P., 25 Holland rd., South Orange
 Martinetti, Carlo D., 311 Central av., Orange
 Martland, Harrison S., 180 Clinton av., Newark
 Matheke, O. G., 328 Sussex av., Newark
 Matheson, G. E., 649 Central av., East Orange
 Matthews, H. E., 504 Hillside av., Orange
 Matthews, W. F., 11 Seymour av., Montclair
 May, Ernst A., 965 Broad st., Newark
 Medd, John C., 25 Curtis pl., Maplewood
 Meehan, Martin M., 201 Joralemon st., Belleville
 Meeker, Frank B., 355 Clifton av., Newark
 Meeker, Irving A., 581 Valley rd., U. Montclair
 Mellen, S. H., 863 Mt. Prospect av., Newark
 Menk, Paul E., 31 Lincoln Park, Newark
 Merliss, Eugene, 386 Clinton av., Newark
 Merselis, John G., 110 Irvington av., S. Orange
 Metsky, Joseph, 777 High st., Newark
 Meurlin, Alfred, 158 Harrison st., E. Orange
 Mierau, E. W., 1096 Sanford av., Irvington
 Miller, Jos. A., 364 Prospect st., South Orange
 Minard, E. L., 140 4th av., East Orange
 Minier, Carl L., 171 Ellery st., Newark
 Minnefor, C. A., 126 Carolina av., Newark
 Minningham, Wm. D., 18 Headen ter., Newark
 Mishell, Daniel R., 730 Prospect st., Maplewood
 Mitchell, August J., 59 South st., Newark
 Mockridge, Oscar A., 8 S. Mountain av., Montcl'r
 Mohrbacher, J. J., 37 Osborne ter., Newark
 Moore, Dean C., 73 N. Arlington av., E. Orange
 Moore, John D., 6 Washington av., Bloomfield
 Morgan, Browne, 260 Liberty st., Bloomfield
 Morris, Clement, 513 Broadway, Newark
 Morrison, Caldwell, 379 7th av., Newark
 Morrison, J. Bennett, 66 Milford av., Newark
 Motzenbecker, P. F., 31 Lincoln Park, Newark
 Motzenbecker, Wm., 16 Milford av., Newark
 Moulton, Chas. D., 122 Park av., East Orange
 Mount, Walter B., 21 Plymouth st., Montclair
 Muller, Joseph H., 867 S. 13th st., Newark
 Mullin, Raymond J., 857 S. 11th st., Newark
 Mullins, R. L., 144 Harrison st., East Orange
 Murray, Harold A., 624 Mt. Prospect av., New'k
 Muta, Samuel A., 47 Park av., West Orange
 Nappi, P. E., 215 Mt. Prospect av., Newark
 Nash, Albert B., 10 South 13th st., Newark
 Nash, Alexander E., 20 Forest av., Verona
 Nash, Herman S., 865 S. 11th st., Newark
 Nash, Wm. G., 20 Clinton st., Newark
 Nataro, Joseph, 172 Littleton av., Newark
 Neare, Clifford B., 2 Hawthorne av., E. Orange
 Nemzek, Wm. P. B., 141 Ridge rd., Arlington
 Newman, Grace T., 339 Grove st., Montclair
 Newman, Julius, 10 Osborne ter., Newark
 Ney, J. Marshall, 78 Clinton av., Newark
 Nimaroff, M., 265 Union av., Irvington
 Noll, Louis, 1044 Clinton av., Irvington
 Norris, Henry M., 49 Prospect st., East Orange
 Nyiri, William, 30 Van Ness pl., Newark
 Obuchowski, Henry T., 86 Belmont av., Newark
 O'Connor, D. F., 671 Broad st., Newark
 O'Connor, M. J., 98 Shanley av., Newark
 O'Crowley, Clarence R., 31 Lincoln Park, New'k
 Olcott, Geo. P., 144 Harrison st., East Orange
 Oleynick, S., 107 Clinton av., Newark
 Olini, Joseph J., 30 West Market st., Newark
 O'Neil, Chas. L., 11 N. 7th st., Newark
 Opdyke, C. P., 10 Summit rd., Verona
 Opdyke, Gordon McC., 10 Summit rd., Verona
 Openchowski, M., 52 Jones st., Newark
 Orloff, Samuel, 97 Lyons av., Newark
 Orton, Henry B., 24 Commerce st., Newark
 *Ost, Henry B., 1109 Broad st., Newark
 Paddock, Royce, 965 Broad st., Newark
 Palmer, Gideon H., 28 Winans st., E. Orange
 Palmer, H. S., 257 Mulberry st., Newark
 Panitch, Wm., 352 Belmont av., Newark
 Pannell, Walter L., 7 Prospect st., East Orange
 Pannullo, John N., 266 Van Buren st., Newark
 Parent, Sol., 924 S. 20th st., Newark
 Parisi, Anthony, 150 Hunterdon st., Newark
 Parker, John E., 385 Park av., Orange
 Parsonnet, Eugene V., 31 Lincoln Park, Newark
 Paul, G. A., 765 Lyons av., Irvington
 Payne, Guy, Overbrook Hospital, Cedar Grove
 Peer, Lyndon A., 965 Broad st., Newark
 Pendexter, S. E., 11 S. Arlington av., E. Orange
 Pennington, A. W., 1195 Broad st., Bloomfield
 Petry, William, 109 Treacy av., Newark
 Phillips, A. A., 68 West Market st., Newark
 Pilch, Arthur C., 1 Willard av., Bloomfield
 Pinneo, Frank W., 439 Mt. Prospect av., Newark
 Pizzi, Francis W., 205 Park av., Orange
 Plant, J. S., 467 High st., Newark
 Plante, Amos A., 228 Dunnell rd., Maplewood
 Polevski, J., 682 High st., Newark
 Pollis, Nicholas, 562 High st., Newark
 Polow, Benjamin, 318 Hawthorne av., Newark
 Pomeranz, R., 31 Lincoln Park, Newark
 Potter, Raymond T., 144 Harrison st., E. Orange
 *Potter, Robert C., 25 Fulton st., Newark
 Preston, Perry B., 12 Palm st., Newark
 Price, Nathaniel G., 31 Lincoln Park, Newark
 Pringle, F. A., 192 Claremont av., Montclair
 Pudney, W. R., 11 Seymour st., Montclair
 Quinby, Wm. O'Gorman, 14 James st., Newark
 Rado, William, 190 Clinton av., Newark
 Rados, Andrew, 299 Clinton av., Newark
 Ragoff, George A., 291 Osborne ter., Newark
 Ramos, Nicholas J., 188 Market st., Newark
 Ranson, Bris. B. J., 601 Ridgew'd av., Maplew'd
 Rathgeber, Chas. F., 18 William st., E. Orange
 Rathgeber, Wm. M., 249 Roseville av., Newark
 Ravitz, S. F., 1113 Broad st., Newark
 Rawitz, Sidney B., 31 Lincoln Park, Newark
 Reich, A. L., 83 Lyons av., Newark
 Reich, Henry, 31 Lincoln Park, Newark
 Reilly, C. J., 321 S. 9th st., Newark
 Reilly, John V., 472 Sanford av., Newark
 Reissman, E., 31 Lincoln Park, Newark
 Reitter, G. S., 144 Harrison st., East Orange
 Renzuli, Francesco, 228 S. 7th st., Newark
 RePass, Paul E., 42 Washington st., E. Orange
 Rettig, I. L., 36 Milford av., Newark
 Ribbans, Robert C., 63 Central av., Newark
 Rich, Charles, 191 Littleton av., Newark
 Rich, Harry H., 32 Broad st., Newark
 Richardson, Arthur, 60 Orange rd., Montclair
 Ricketts, Henry E., 31 Lincoln Park, Newark
 Rigg, S. B., 506 Ridgewood av., Glen Ridge
 Riggins, Edwin N., 161 No. Arlington av., E. Or.
 Ripley, Edward W., 7 Trinity pl., Montclair
 Rizzolo, Edward M., 250 Mt. Prospect av., New'k
 Robbin, Lewis, 18 Clinton pl., Newark
 Robbins, Charles M., 31 Lincoln Park, Newark
 Roberts, D. C., 1536 N. Broad st., New Or'ns, Fla.
 Roberts, W. A., 9 Forest av., Caldwell
 Robie, T. R., 452 Richmond av., Maplewood
 Rocco, Frank, 729 Summer av., Newark

ESSEX COUNTY—Continued

- Roeber, Wm. J., 21 Nesbit ter., Irvington
 Rogers, Harry, 144 Harrison st., E. Orange
 Rogers, Richard M., 1 Wallace st., Newark
 Rogers, Robert H., 49 9th av., Newark
 Roh, Robert F., 671 Broad st., Newark
 Rosenberg, L. Charles, 11 Murray st., Newark
 Rosenstein, S. L., 557 Clinton av., Newark
 Roth, Oswald H., 210 Littleton av., Newark
 Roth, S. R., 31 Lincoln Park, Newark
 Rothenberg, Samuel, 1 Hillside av., Newark
 Rothhouse, Burnet, 19 Lincoln Park, Newark
 Rothseid Abraham, 29 Scheerer av., Newark
 Rothstein, I. B., 16 Lyons av., Newark
 Rubinow, Saul M., 755 High st., Newark
 Rumage, Wm. T., 44 Walnut st., Newark
 Runyan, Wm. J., 106 Broad st., Bloomfield
 Russell, L. C., 192 Clinton av., Newark
 Salsberg, Ralph H., 325 Peshine av., Newark
 Samuel, Jerome H., 299 Clinton av., Newark
 Santora, Phillip J., 192 Elm st., Newark
 Saslow, Benj., 680 Clinton av., Newark
 Satohwell, H. H., 640 Stuyvesant av., Irvington
 Sbarra, F., 531 W. Market st., Newark
 Schaaf, Royal A., 413 Mt. Prospect av., Newark
 Schaefer, Eugene P., 12 Harrison pl., Irvington
 Schaffer, Nathan, 94 So. Munn av., E. Orange
 Schectman, Vera, 385 Osborne ter., Newark
 Schiller, Nicholas, 9 Pierce st., Newark
 Schimmelpfennig, R. D., 258 Clarem. av., M'tclair
 Schmukler, Jacob, 29 Rutgers st., Maplewood
 Schneider, Charles A., 694 Clinton av., Newark
 Schneider, Louis, 874 S. 13th st., Newark
 Schramm, Joseph A., 23 Darcy st., Newark
 Schreck, Harry, 139 Roseville av., Newark
 Schulsinger, S., 48 Walnut st., Newark
 Schulte, H. A., 701 Clinton av., Newark
 Scott, R. Hunter, 205 Roseville av., Newark
 Scranton, Chas. W., 31 Washington st., E. Or.
 Scudder, F. D., 63 S. Fullerton av., Montclair
 Seidler, V. B., 16 Plymouth st., Montclair
 Seidler, William F., 29 Rossmore pl., Belleville
 Seidman, E. A., 580 High st., Newark
 Seidman, Marcus, 580 High st., Newark
 Seifert, Edwin A., 247 Claremont av., Montclair
 Sellers, Robert R., 19 Chestnut st., Newark
 Shannon, J. B., 56 Church st., Montclair
 Shaul, F. G., 10 Washington st., Bloomfield
 Sherman, Alton L., 26 Northfield av., W. Orange
 Sherman, A. Russell, 671 Broad st., Newark
 Sherman, Elbert S., 671 Broad st., Newark
 Shill, Benjamin, 131 Renner av., Newark
 Shockley, Francis M., 144 Harrison st., E. Orange
 Shor, David M., 32 S. Munn av., E. Orange
 Siegel, J. W., 96 S. 10th st., Newark
 Silver, H. B., 190 Clinton av., Newark
 Silverstein, Benj. J., 32 Hillside av., Newark
 Silverstein, J. M., 73 Main st., Millburn
 Simmons, Albert V., 720 Prospect st., Maplewood
 Simms, Geo. F., 541 Page st., Lyndhurst
 Simon, Ludwig, 201 Ferry st., Newark
 Singer, Max, 147 Johnson av., Newark
 Skwisky, Joseph, 170 Hawthorne av., Newark
 Smalley, Sara D., 530 Clifton av., Newark
 Smith, Byron J., 796 S. Orange av., Newark
 Smith, E. L., Soho Hospital, Belleville
 Smith, G. H., 136 Evergreen pl., East Orange
 Smith, H. G., Cedar Grove
 Smith, Harold W., 179 Clinton av., Orange
 Smith, J. J., 325 13th av., Newark
 Smith, L. H., 32 Washington st., East Orange
 Smith, T. A., Short Hills
 Snavelly, Earl H., City Hospital, Newark
 Sobin, Julius, 24 Waverly av., Newark
 Somers, Fred L., 144 Harrison st., Orange
 Soschin, Samuel J., 299 Clinton av., Newark
 Spallone, Jos. C., 123 Mt. Prospect av., Newark
 Sprague, Edward W., 86 Washington st., Newark
 Staehle, Richard H., 34 Lyons av., Newark
 Stahl, Alfred, 55 Lincoln Park, Newark
 Stahl, Charles, 659 Sanford av., Newark
 Steiner, Edwin, 19 Lincoln Park, Newark
 Stevens, J. Thompson, 55 Park st., Montclair
 Stewart, Robert G., 79 Midland av., Montclair
 Stickles, Lloyd C., 49 Parkhurst st., Newark
 Stokes, Earl B., 725 High st., East Orange
 Straub, Herbert H., 242 Springdale av., E. Or.
 Sutton, Jos. G., Essex County Hosp., Cedar Gr.
 Swain, Richard D., 211 Roseville av., Newark
 Symes, Earl H., 161 Kearny av., Kearny
 Synott, Martin J., 63 S. Fullerton av., Montclair
 Szerlip, L., 31 Lincoln Park, Newark
 Talbot, Herbert S., 144 Harrison st., E. Orange
 Tansey, Wm. A., 520 Sanford av., Newark
 Tarbell, Harold, 11 Pennington st., Newark
 Taylor, Herbert G., 590 Ridge av., Maplewood
 Teeter, Charles E., 418 Orange st., Newark
 Teimer, Theodore, 17 Hillside av., Newark
 Tenney, Albert S., 164 Harrison st., E. Orange
 Terriberry, W. K., Room 800, 26 Bigaw, New York
 Thomas, J. H., Jr., 270 Lenox av., S. Orange
 Thomas, Wm. B. S., 1 Park pl., Bloomfield
 Thompson, Arthur F., 157 Harrison st., E. Orange
 Thompson, Austin B., 479 Highland av., Orange
 Thompson, C. S., Fair Oaks Sanatorium, Summit
 Tildon, John W., 54 N. Clinton st., E. Orange
 Tirrell, C. M., 36 Spruce st., Newark
 Titman, Russell E., 275 Dodd st., East Orange
 Tobey, F. J., 11 Hazelwood av., Newark
 Tomassi, Chas. F., 173 Lafayette st., Newark
 Tomec, Richard F., 55 S. Park st., Montclair
 Toye, John E., 590 Kearny av., Arlington
 Trainor, James H., 40 Johnson av., Newark
 Turi, A., 57 Garside st., Newark
 Turner, C. F., Grove & Camb. sts., Montclair
 Tutchulte, E., 111 Mt. Pleasant av., Newark
 Twitchell, A. B., 162 S. Orange av., S. Orange
 Tymeson, Walter R., 310 Main st., Orange
 Ulan, Oscar, 170 Fleming av., Newark
 Vail, Herbert B., 301 Washington av., Belleville
 Vanderhoff, Irving M., 9 Clinton st., Newark
 Van Der Veer, H. G., 295 Montgomery st., Bl'mf'd
 Van Emburg, Geo. H., 575 Belgrove dr., Arl'gt'n
 Van Geison, Edward J., 17 Park pl., Bloomfield
 Vannatta, Geo. W., 224 N. Park st., East Orange
 Van Ness, H. Roy, 444 Parker st., Newark
 Verbeck, George B., 26 Washburn pl., Caldwell
 VonHofe, Fred'k H., 255 Conway Court, E. Orange
 Voorhees, Florence E., 83 Lincoln Park, Newark
 Vreeland, Ralph D., 333 Lyons av., Newark
 Wakeley, W. E., 521 Main st., E. Orange
 *Wakeley, William A., 120 Main st., Orange
 Wallhauser, Henry J. F., 31 Lincoln Park, New'k
 Walton, R. W., 48 N. Fullerton av., Montclair
 Wambagans, M., 44 Devine st., Newark
 Ward, Gertrude P., 41 Park pl., Bloomfield
 Ward, Wm. R., 112 Chancellor av., Newark
 Warner, Wm. H. A., 444 Central av., E. Orange
 Weber, Francis C., 286 Mt. Prospect av., Newark
 Weber, C. Fred., 71 Lincoln Park, Newark
 Weinberg, Maurice M., 377 Osborne ter., Newark
 Weinmann, Max H., 714 Scotland rd., Orange
 Weiss, Louis, 849 S. 11th st., Newark
 Weiss, Selma, 2 Stratford pl., Newark
 Weller, Arthur, 19 Hillyer st., Orange

ESSEX COUNTY—Continued

*Wendel, August V., 205 Littleton av., Newark
 Whelan, E. P., Mountain av., W. Orange
 Wheeler, W. K., 31 Lincoln Park, Newark
 Wherry, Elmer G., 323 Clinton av., Newark
 White, Robert R., 25 S. Munn av., East Orange
 Wilkes, Arthur C., 36 Osborne ter., Newark
 Willan, E. H., 77 S. Munn av., E. Orange
 Willey, F. Parker, 11 Park pl., Bloomfield
 *Williams, Irving D., 293 Central Pk. W., N. York
 Willner, Irving, 18 Waverly av., Newark
 Willson, James H., 144 Harrison st., East Orange
 Wintsch, Carl H., 841 S. 12th st., Newark
 Wolfe, J. C., 56 Church st., Montclair
 Wolfe, J. S., 44 Watsessing av., Bloomfield
 Wolfe, William W., 383 Mulberry st., Newark
 Wood, E. LeRoy, 192 Roseville av., Newark
 Woodworth, L. J., 307 Montgomery st., Bloomfield
 Woolf, Bernard H., 15 Hedden ter., Newark
 Wort, Frederick J., Jr., 1080 Broad st., Newark
 Wrensch, Alex. E., 79 Valley rd, Montclair
 Wyatt, Joseph H., 135 Clinton av., Newark
 Wyker, Arthur W., 1 Park pl., Bloomfield
 Yaguda, Asher, 88 Clinton av., Newark
 Ylvisaker, Lauritz, Prud. Ins. Co., Newark
 Young, I. H., 654 Lyons av., Irvington
 Young, John H., 37 N. Fullerton av., Montclair
 Zehnder, A. Charles, 188 Roseville av., Newark
 Zimmerman, R., 1 Baldwin av., Newark
 Zvaifler, Nathan, 91 Clinton av., Newark
 Zweigel, I., 92 Sunnyside ter., East Orange

Associate Members

Agnew, Hobart M., 27 S. Fullerton av., Montclair
 Alford, Ralph I., 9 N. Mountain av., Montclair
 Allen, Raymond N., 114 Park st., Orange
 Applebaum, Irving L., 304 Fairmount av., N'w'k
 Aronowitz, Harry, 68 Weequahic av., Newark
 Beling, C. Abbott, 111 Clinton av., Newark
 Blinn, Arthur R., Homeo. Hosp., East Orange
 Caggiano, A. P., 136 Grove st., Montclair
 Cheskin, L. T., 915 Hunterdon st., Newark
 Chimacoff, H., 171 Elizabeth av., Newark
 Cohen, I. E., 67 Hunterdon st., Newark
 Colton, Ethan T., Jr., 220 Park st., Montclair
 Davis, Thomas C., 16 Old Short Hills rd., Millb'n
 DeFino, F. J., 463 N. 7th st., Newark
 Deignan, Wm. L., 257 Dodd st., E. Orange
 Deutel, O. R., 283 Franklin st., Bloomfield
 Dranow, Paul, 205 Franklin av., Nutley
 Dulany, Theo. L., 157 W. Market st., Newark
 Post, William H., 107 Franklin st., Belleville
 Freidman, Harry, 721 S. 16th st., Newark

Golden, Clement H., 81 Seymour av., Newark
 Griffin, Guy B., 197 S. Centre st., Orange
 Hantman, Harold, 49 Farley av., Newark
 Hayes, Gerald W., 96 N. Walnut st., E. Orange
 Hubach, M. F., 202 Broad st., Bloomfield
 Israeloff, Howard M., 7 Frederick ter., Irvington
 Jost, Franz, 98 Washington st., E. Orange
 Lee, John J., 66 Central av., Orange
 Levitt, Jesse N., 26 Clinton pl., Newark
 Liccese, Emanuel, 98 Jefferson st., Newark
 Licks, Frederick C., 152 Clinton av., Newark
 Maggio, George A., 110 Fleming av., Newark
 Mangona, Phillip, 241 S. 7th st., Newark
 Mangona, Ph., 241 S. 7th st., Newark
 Massengill, F., 31 Clinton st., Newark
 Masterson, John F., 94 Myrtle av., Irvington
 Mintx, Abraham, 108 Treacy av., Newark
 Moeckel, C. W., 34 Plymouth st., Montclair
 Nacca, Carl A., 86 N. Essex av., Orange
 Nevius, Wm. B., 61 N. Fullerton av., E. Orange
 Paul, H. Carl, 24 Hanford pl., Caldwell
 Pavia, John R., 365 Chancellor av., Newark
 Perham, Bertram S., 199 Lorraine av., U. Montc'r
 Pilloni, Louis, 27 Park pl., Bloomfield
 Plain, I. H., 2 Stratford pl., Newark
 Quad, Clifford W., 53 Northfield av., W. Orange
 Roberts, A. H., 24 S. 9th st., Newark
 Rosamilia, Robt. E., 48 N. 7th st., Newark
 Russomanno, R. L., 181 Clinton av., Newark
 Sasso, Albert, 99 Parker st., Newark
 Sax, Max T., 84 Grove st., Bloomfield
 Sheehan, D. C., 773 Sanford av., Newark
 Sisson, Nelson W., 144 Harrison st., E. Orange
 Stage, Earl, 601 Clinton av., Newark
 Stiles, Clarence C., 114 N. 19th st., East Orange
 Stoddard, Gordon V., 41 S. Munn av., E. Orange
 Thum, K. W., 354 Main st., West Orange
 Tillis, Herman H., 11 Bergen st., Newark
 Van Duzer, R. B., 226 N. Park st., East Orange
 Varmus, Frank, 389 Leslie st., Newark
 Weisman, Jos. C., 99 Elm st., West Orange
 Zimmerman, Coler, 82 N. Arlington av., E. Or.
 Zweibel, Leonard, 29 Girard pl., Newark

Number of Associate Members, 63.

Number of active members and basis of representation, 731, March 15, 1934.

100 per cent paid up membership, March 15, 1934.

*Deceased.

GLOUCESTER COUNTY (8)

Society organized December, 1818. Meets third Thursday of each month, October to June inclusive. Social session in September. Annual meeting in November.

President

Livengood, B. A., Swedesboro

Vice-President

Ristine, E. R., Westville

Secretary and Treasurer

Hollinshed, Ralph K., Westville

Reporter

Diverty, Henry B., Woodbury

Censors

Stout, H. W., Chairman, Wenonah
 Sinexon, H. L., Paulsboro
 Ulmer, Chester I., Gibbstown

Ashcraft, Samuel F., Mullica Hill
 Barrows, Victor, Pitman
 Black, Alan B., Clarksboro
 Brewer, William, Woodbury
 Burkett, William, Pitman
 Campbell, Duncan, Woodbury
 Carpenter, William H., Woodbury
 Chalfant, H. Bailly, Pitman
 Crain, W. E., Mt. Ephraim
 Diverty, Henry B., Woodbury
 Downs, Elwood E., Woodbury
 Fishler, C. F., Clayton
 Fooder, H. M., Williamstown
 Gairdner, T. M., Gibbstown
 Hillegas, E. J., Mantua
 Hollinshed, Ralph K., Westville

GLOUCESTER COUNTY—Continued

Knight, I. Warner, Pitman
 Livengood, B. A., Swedesboro
 Lumis, M. F., Pitman
 Moore, Ralph L., Woodbury
 Nelson, Harry, Woodbury
 Pedrick, Charles D., Glassboro
 Pedrick, William W., Glassboro
 Rhoads, S. Creadick, Westville
 Ristine, Edwin R., Westville
 Rogers, Dorothy, Woodbury
 Ruttenberg, Louis, Mantua
 Sheets, C. C., Paulsboro
 Sherman, Fuller G., Woodbury

Sinexon, Harry L., Paulsboro
 Stewart, Irving J., Swedesboro
 Stout, Harry Wilson, Wenonah
 Ulmer, Chester I., Gibbstown
 Underwood, J. Harris, Woodbury
 Weems, Don, Wenonah
 Wood, Oram A., Paulsboro
 Wright, H. W., Williamstown

Number of active members and basis of representation, 37.

100 per cent paid up membership, March 15, 1934.

HUDSON COUNTY (9)

Society organized October 11, 1851. Meets first Tuesday evening of each month, October to May, inclusive. Annual meeting in October.

President

Street, Daniel B., Jersey City

Vice-President

Chapman, E. J., Jersey City

Secretary

Perlberg, Harry J., Jersey City

Treasurer

Kelley, Charles B., Jersey City

Reporter

Connell, John N., Jersey City

Censors

Cassidy, J. M., Jersey City
 Jaffin, A. E., Jersey City
 Ballinger, R. L., Arlington

Adams, Samuel, 29 Highland av., Jersey City
 Adler, Joseph, 933 Ave. C., Bayonne
 Africano, J. V., 4246 Hudson blvd., Union City
 Ainsley, H. Bryson, 246 Union st., Jersey City
 Alexander, Hugo, 1029 Garden st., Hoboken
 Allen, Isaac L., 521 Palisade ave., Union City
 Alpert, Edward, 661 Jersey av., Jersey City
 Alter, Nicholas M., 410 Fairmount av., Jersey City
 Andreae, Paul, 52 Werner av., Jersey City
 Angelo, Jos. A., 1190 Paterson Plank rd., Secaucus
 Aria, Michael, 497 Mercer st., Jersey City
 Arlitz, William J., 107 Newark st., Hoboken
 Ash, Arthur F., 710 Boulevard East, Weehawken
 Auriemma, Michael, 419 Adams st., Hoboken
 Axford, W. H., Chester
 Baechler, Jules, 439 16th st., W. New York
 Bahnson, Conrad M., 170 Bowers st., Jersey City
 Bailyn, Emanuel, 331 16th st., W. New York
 Banach, Leon, 2747 Boulevard, Jersey City
 Barbarito, William N., 135 Bentley av., Jer. City
 Barishaw, S. B., 5 Bentley av., Jersey City
 Barrett, A. F., 835 Montgomery st., Jersey City
 *Bauman, John J., 2672 Boulevard, Jersey City
 Behrens, Herman, 312 Webster av., Jersey City
 Ben-Asher, Solomon, 260 Bergen av., Jer. City
 Benjamin, Harold C., 59 Crescent av., Jersey City
 Berlin, J. I., 9 Gifford av., Jersey City
 Binder, Joseph, 422 Bergen av., Jersey City
 Bitten, Robert M., 33 Romaine av., Jersey City
 Blakey, A. P., 475 Jersey av., Jersey City
 *Blanchard, O. R., 37 Clinton av., Jersey City
 Bookrajian, Edw. N., 5436 Hudson blvd., N.B'rg'n
 Borshaw, Hyman, 108 Bentley av., Jersey City
 Bortone, Frank, 2765 Boulevard, Jersey City
 Boselli, Emile H., 614 15th st., Union City
 Botti, John A., 236 Summit av., Jersey City
 Bowen, Horace, 2787 Boulevard, Jersey City
 Bowyer, Frank F., 50 Gifford av., Jersey City
 Brady, Thos. S., 678 Avenue C. Bayonne
 Brady, William, 403 46th st., Union City
 Branch, W. Harold, 190 Duncan av., Jersey City
 Brandenburg, Leo W., 4260 Boulevard, Union City
 Brauer, Selig, 234 Bergen av., Jersey City
 Braunstein, S. C., 424 13th st., West New York
 Braunstein, Wm. P., 831 Boulevard E., W'hawk'n
 Brennock, Thos. McG., 3 Webster av., Jersey City
 Brick, G. J., 43 Cottage st., Jersey City
 Broesser, H. V., 105 Newark av., Hoboken
 Brooke, W. W., 915 Ave. C, Bayonne
 Brophy, Francis X., 2511 Boulevard, Jersey City
 Brozdowski, John J., 554½ Jersey av., Jersey City
 Bruder, A. J., 344 Fairmount av., Jersey City
 Butler, Vincent P., 921 Bergen av., Jersey City
 Callery, Wm., 4 Columbia ter., Weehawken
 Cannon, Edw. A., 5360 Hudson blvd., N. Bergen
 Caridi, Salvatore, 465 Bergenline av., W. New Y'k
 Carr, Mary B., 1 Astor pl., Jersey City
 Cassidy, John M., 1913 Boulevard, Jersey City
 Chapman, E. J., 203 Danforth av., Jersey City
 Chayes, Sidney, 980 Ave. C, Bayonne
 Child, Frank M., 1222 Bloomfield st., Hoboken
 Christian, Henry A., 111 Fairview av., Jersey City
 Clark, Chas. C., 461 New York av., Union City
 Cobham, James L., 78 Brinkerhoff st., Jer. City
 Cohen, Harry F., 660 Jersey av., Jersey City
 Cohen, Herman, 489 Jersey av., Jersey City
 Cohen, Herman N., 714 Park av., Hoboken
 Cohen, Samuel A., 112 Mercer st., Jersey City
 Comora, Herman C., 317 16th st., West New York
 Connell, Emmet J., 2227 Blvd., Jersey City
 Connell, John, 977 Summit av., Jersey City
 Connell, John N., 26 Carlton av., Jersey City
 Connolly, Thos. W., 921 Bergen av., Jersey City
 Conty, Anthony J., 318 48th st., Union City
 Cosgrove, Samuel A., 254 Union st., Jersey City
 Cropper, Chas. W., 2540 Hudson Blvd., Jer. City
 Crowley, Leo F., 148 Belmont av., Jersey City
 Culver, Geo. M., 25 Glenwood av., Jersey City
 Culver, S. Herbert, 75 Magnolia av., Jersey City
 Curtis, Grant P., 312 36th st., Union City
 D'Acerno, P., 346 Palisade av., Union City
 Daly, E. J., 921 Bergen av., Jersey City
 Davey, Thomas N., 41 West 33rd st., Bayonne
 Deary, Louis E., 31 W. 37th st., Bayonne
 Decker, Clinton L., 520 Main st., Boonton
 DeFuccio, C. P., 47 Glenwood av., Jersey City
 DeMeritt, C. L., 415 32d st., Hoboken
 Dexter, Harriet E. T., 903 Avenue C. Bayonne
 Dillingham, W. I., 431 15th st., West New York

HUDSON COUNTY—Continued

- Dodson, Louis, 592 Jersey av., Jersey City
 Dolganos, Moses, 268 Palisade av., Jersey City
 Donohoe, Lucius F., 140 West 8th st., Bayonne
 Doody, Wm. M., 19 Bentley av., Jersey City
 Doran, Ralph J., 200 11th st., Hoboken
 Doran, Wm. G., 921 Bergen av., Jersey City
 Dougherty, Dan. D., 206 10th st., Hoboken
 Draesel, Charles, 230 Webster av., Jersey City
 Duckett, Warren J., 21 Carlton av., Jersey City
 Dukes, H. R., 220 Kearny av., Kearny
 Eckert, William, 672 Palisade av., Union City
 Edgar, Joseph A., 71 Congress st., Jersey City
 Edwards, Lena F., 358 Pacific av., Jersey City
 Elsasser, Theo., 906 Park av., Woodcliff
 Enright, J. G., 25 Kensington av., Jersey City
 Evans, James L., 893 Park av., N. Bergen
 Facciolo, Frank, 562 Boulevard, Bayonne
 Faison, John B., 45 Glenwood av., Jersey City
 Fauquier, Leonard, 2554 Boulevard, Jersey City
 Feit, Herman, 921 Bergen av., Jersey City
 Fellman, M., 118 Jewett av., Jersey City
 Ferenczi, Louis J., 33 Edwards st., Bayonne
 Fineberg, Bernard J., 574 Bergen av., Jersey City
 Fineberg, Jacob, 50 Glenwood av., Jersey City
 Finke, Chas. H., 317 York st., Jersey City
 Finn, D. F., Trust Co. Bldg. of N. J., Jersey City
 Finn, Frederick A., 921 Bergen av., Jersey City
 Flaherty, M. E., 36 Glenwood av., Jersey City
 Flichtefeld, Morris, 283 4th st., Jersey City
 Forman, H. S., 640 Bergen av., Jersey City
 Frank, Morris, 920 Ave. C, Bayonne
 Franklin, I. Harold, 191 Palisade av., Jersey City
 Franklin, Louis, 191 Palisade av., Jersey City
 Friele, Wm., 25 Tonnele av., Jersey City
 Frundt, Oscar C., 92 Bartholdi av., Jersey City
 Furlonge, H. Rowland, 333 Forrest st., Jersey City
 *Gardner, John W., 636 Ocean av., Jersey City
 Ghee, Euclid P., 115 Clairmont av., Jersey City
 Gille, Hugo, 149 Congress st., Jersey City
 Ginsberg, George, 624 Bloomfield st., Hoboken
 Gleeson, Wm. John, 37 Monticello av., Jersey City
 Godlin, David R., 610 36th st., N. Bergen
 Goudy, E. S., 187 Kearny av., Kearny
 Gould, J. H., 696 Ave. C, Bayonne
 Granelli, H. A., 213 Garden st., Hoboken
 Greenberg, Philip, 1902 Hudson blvd., Jersey City
 Greene, Albert D., 195 Palisade av., Union City
 Greissinger, Karl, 422 20th st., West New York
 Hall, Perry O., 254 Union st., Jersey City
 Halligan, Earl J., 254 Montgomery st., Jer. City
 Halligan, Harold J., 254 Montgomery st., Jer. City
 Halpern, Sophia L., 271 Palisade av., Union City
 *Hamill, P. J., 50 Journal Square, Jersey City
 Hammer, Walter P., 322 15th st., W. New York
 Hardenberg, D. S., 347 Communipaw av., J. City
 Harter, Louis F., 174 Bowers st., Jersey City
 Hartwell, H. A., 777 Boulevard East, Weehawken
 Harvey, John W., 818 Ave. C, Bayonne
 Hasking, Arthur P., 318 Montgomery st., Jer. City
 Heilbrunn, Julius, 135 Belmont Ave., Jersey City
 Heintzelman, B. S., 19 W. 33rd st., Bayonne
 Hekimian, J. H., 468 Palisade av., Weehawken
 Hernandez, Manuel, 1974 Hudson blvd., Jer. City
 Herradora, J. R., 921 Bergen av., Jersey City
 Higgins, G. L., 94 Lembeck av., Jersey City
 Higgins, Thos. A., 2616 Hudson blvd., Jersey City
 Hill, William F., 108 Grand st., Jersey City
 Hoffman, P., 2672 Boulevard, Jersey City
 Hommel, P. E., 689 Bergen av., Jersey City
 Hoops, Harold J., 167 Ege av., Jersey City
 Introcaso, D. A., 45 Crescent av., Jersey City
 Ishkhanian, N. J., 656 Palisade av., West New York
 Jacks, Oscar, 476 Mercer st., Jersey City
 Jacques, J. Eugenia, 74 Waverly st., Jersey City
 Jaffe, Herman, 112 Bergen av., Jersey City
 Jaffin, A. E., 41 Emory st., Jersey City
 Jentz, John H., 63 Sherman pl., Jersey City
 Jones, J. Morgan, Valley rd., R.F.D., Oakland
 Joseph, B. M., 2771 Boulevard, Jersey City
 Justin, Arthur W., 41 Fulton st., Weehawken
 Justin, J. Clement, 1074 Dearborn rd., Palisade
 Keegan, Thos. D., 75 Bentley av., Jersey City
 Kelley, Chas. B., Trust Co. of N. J. Bldg., Jer. City
 Kelly, Bernard S., 1954 Boulevard, Jersey City
 Kelly, James E., 160 Wegman Pkwy., Jersey City
 Kiley, Eugene M., 920 Hudson st., Hoboken
 King, Geo. W., Hud. Co. Hos. for Insane, Secaucus
 Klugman, Louis W., 375 Ave. C, Bayonne
 Kolb, J. M., 725 16th st., Union City
 Kooperstein, Samuel, 395 Ogden av., Jersey City
 Koppel, Joseph, 921 Bergen av., Jersey City
 Koppel, Leo A., 921 Bergen av., Jersey City
 Kresch, Philip, 42 W. 22nd st., Bayonne
 Kuhlmann, Alvin E., 527 37th st., Union City
 *Lambert, F. E., 157 Ocean av., Jersey City
 Lange, Louis C., 50 Clifton ter., Weehawken
 Largay, Arthur O., 937 Ave. C, Bayonne
 Larkey, Charles J., 700 Ave. C, Bayonne
 *Larkin, Joseph J., 546 Bramhall av., Jersey City
 Lawsing, G. Condi, 443 22nd st., West New York
 Lefkowitz, Jacob H., 445 20th st., West New York
 Leining, Albert, 1 4th st., Weehawken
 Lemmerz, Theodore H., 141 Magnolia av., Jer. City
 Levine, G. I., 1861 Boulevard, Jersey City
 Lewis, Livingston L., 712 Washington st., Hob'k'n
 Linden, Mortimer H., 45 Clendenny av., Jer. City
 Lindroth, Lawrence V., 4633 Hudson Blvd., J. City
 Little, Alonzo W., 120 Arlington av., Jersey City
 Londrigan, Jos. F., 535 Wash'g'tn st., Hoboken
 Long, Miles T., 2150 Boulevard, Jersey City
 Luczynski, Edw., 38 W. 26th st., Bayonne
 Luippold, E. J., Columbia ter., Weehawken
 Lupin, Edward E., 727 Ave. C, Bayonne
 Lynch, Roland J., 93 Fairview av., Jersey City
 McDede, J. Searle, 215 Ege av., Jersey City
 McDonald, F. R., 79 Summit av., Jersey City
 McLean, Herbert E., 92 Fairview av., Jer. City
 McLean, Hugh A., 414 17th st., West New York
 *McLean, John J., 92 Fairview av., Jersey City
 McLoughlin, Frank J., 558 Jersey av., Jer. City
 Macchia, Benj. J., 262 Montgomery st., Jer. City
 Madaras, John F., 907 Ave. C, Bayonne
 Madden, Wm. L., 30 Kensington av., Jersey City
 Malladieu, Frank W., 16 Monticello av., Jer. City
 Mangone, Geo. F., 171 Palisade av., Union City
 Maras, Peter E., 80 Tonnele av., Jersey City
 Markowitz, B. B., 2157 Boulevard, Jersey City
 Markowitz, Irwin, 2157 Boulevard, Jersey City
 Marks, David M., 298 Fourth st., Jersey City
 Marshak, Martin I., 679 Ave. C, Bayonne
 Marshall, Frank A., 200 Jane st., Weehawken
 Matera, Joseph, 506 Garden st., Hoboken
 Mathesheimer, J. L., 280 Old Bergen rd., Jer. City
 Matthews, Wm. J., 938 Hudson st., Hoboken
 Maturi, V. E., 814 Boulevard, Bayonne
 Maver, Wm. W., 532 Bergen av., Jersey City
 Mead, Walter G., 699 Kearny av., Arlington
 Meehan, Geo. Edw., 117 Mercer st., Jersey City
 Meltsner, L., 904 Hudson st., Hoboken
 Mendelsohn, Lewis, 272 Montgomery st., Jer. City
 Mersheimer, Chris. H., 15 Reservoir av., Jer. City
 Meyer, Wm., 436 New York av., Union City
 Meyerson, Noah, 428 15th st., W. New York
 Miller, M. H., 311 16th st., West New York

HUDSON COUNTY—Continued

- Miner, Donald, 921 Bergen av., Jersey City
 Monaghan, Wm. J., Secaucus
 Morley, Grace C., 440 Palisade av., Weehawken
 Morris, D. G., 11 W. 26th st., Bayonne
 Mount, Elmer M., 74 Sherman pl., Jersey City
 Mueller, George H., 102 Summit av., Jersey City
 Murphy, Edward A., 1 Britton st., Jersey City
 Murphy, James M., 2757 Boulevard, Jersey City
 Murphy, Leo J., 374 West st., Union City
 Murphy, Patrick H. W., 27 Jefferson av., Jer. C'y
 Murray, Jos. A., 765 Ave. C, Bayonne
 Mustermann, Otto H., 303 48th st., Union City
 Muttart, George W., 702 Ocean av., Jersey City
 Mutter, Alfred A., 75 Beech st., Kearny
 Nafash, M. Shafesk, 402 21st st., Union City
 Nalitt, David I., 28 W. 33rd st., Bayonne
 Natrass, R. B., 204 11th st., Hoboken
 *Nay, Charles K., 164 Palisade av., Jersey City
 Nelson, Aaron, 462 Jersey av., Jersey City
 Nevin, John, 921 Bergen av., Jersey City
 Newman, Abraham J., 70 Sherman pl., Jer. City
 Nicholson, Frank, 895 Summit av., Jersey City
 Niemeyer, Chas. V., 4610 Boulevard, Union City
 Norton, James F., 299 Varick st., Jersey City
 Nuse, Edward F., 550½ Jersey av., Jersey City
 Ockene, Abraham, 495 Palisade av., Union City
 O'Connor, B. A., 314 North 4th st., Harrison
 O'Connor, John J., 434 New York av., Union City
 Oestman, A. W., 932 Summit av., Jersey City
 O'orman, M. W., 931 Bergen av., Jersey City
 O'Hanlon, George, Jersey City Hosp., Jersey City
 Older, Benj., 435 New York av., Union City
 Olpp, A. E., 318 Bergenline av., Union City
 O'Neill, John H., 270 Montgomery st., Jer. City
 Opdyke, L. A., 55 Clinton av., Jersey City
 O'Shea, John J., 135 Shippen st., Weehawken
 Oshrin, Henry, 750 Park av., West New York
 Ovens, R. C., 675 Bergen av., Jersey City
 Owen, Logan S., 938 Hudson st., Hoboken
 Pacicco, Michele, 376 Monmouth st., Jersey City
 Pagliughi, John J., 401 18th st., Union City
 Pearlstein, Frank, 325 16th st., West New York
 Pentel, Louis S., 307 16th st., West New York
 Pellarin, John D., 493 New York av., Union City
 Perkel, Louis L., 3263 Boulevard, Jersey City
 Perlberg, Harry J., 921 Bergen av., Jersey City
 Peters, Chas. M., 921 Bergen av., Jersey City
 Peters, E. A. P., 394 Bergen av., Jersey City
 Peterson, C. A., 921 Washington st., Hoboken
 Pindar, Fred S., 960 Park av., N. Bergen
 Pindar, W. A., 975 Broadway, Woodcliffe
 Pinkerton, Wm. A., 854 Ave. C, Bayonne
 Piskorski, Abdon V., 604 Jersey av., Jersey City
 Plavin, Nathan J., 5407 Hudson blvd., N. Bergen
 Pollak, B. S., Hud. Co. Tbc. Hos. & San., Secaucus
 Pontery, Herbert, 89 Bowers st., Jersey City
 Potter, Benj. Paul, Hud. Co. Tub. San., Secaucus
 Povalski, Alex. W., 1925 Boulevard, Jersey City
 Purdy, Chas. H., 35 Highland av., Jersey City
 Pyle, Louis A., 89 Fairview av., Jersey City
 Pyle, Wallace, 15 Exchange pl., Jersey City
 Quigley, Frederic J., 4622 Boulevard, Union C'y
 Quinn, John J., 234 Pearsall av., Jersey City
 Read, Jessie D., 228 Jewett av., Jersey City
 Rector, Joseph M., 681 Bergen av., Jersey City
 Reingold, Alexander, 221 Garden st., Hoboken
 Fleck, Walter R., 379 Kearny av., Kearny
 Rieman, Aloysius, 3566 Boulevard, Jersey City
 Robbins, Henry B., 144 Mercer st., Jersey City
 Roberts, Edgar W., 21st st. & Palis. av., W. N. Y.
 Rosecrans, James H., 826 Hudson st., Hoboken
 Rosenberg, Albert B., 1921 Blvd., Jersey City
 Rosenberg, J., 692 Bergen av., Jersey City
 Rosenstein, Jacob L., 568 Bergen av., Jersey City
 Rowe, Norman L., 828 Grand st., Jersey City
 Rundlett, Emelia V., 79 Prospect st., Jer. City
 Ruoff, Andrew C., 494 New York av., Union City
 Russell, David L., 690 Bergen av., Jersey City
 Ruvane, J. J., 38 Bentley av., Jersey City
 Sacco, Anthony G., 440 New York av., Union City
 Sachs, Wilbert, 921 Bergen av., Jersey City
 Santangelo, Stephen, 304 Varick st., Jersey City
 Santosky, Benjamin B., 162 Bergen av., Jer. City
 Schapiro, Joseph, 712 Palisade av., Union City
 Schenker, B. N., 246 5th st., Jersey City
 Schept, Samuel S., 523 37th st., Union City
 Schlein, August, 707 Park av., Hoboken
 Schneckendorf, S. J., 179 Harrison av., Jersey C.
 Schneider, Louis A., 412 17th st., West New York
 Schuchner, Wm. F., 264 1st st., Jersey City
 Schuck, Traugott E., 58 9th st., Hoboken
 Schulman, A. S., 4638 Hudson blvd., Union City
 Schurman, E. W., 710 Ocean av., Jersey City
 Schwarz, B. T.D., 2801 Hudson blvd., Jersey City
 Schwartz, Henry J., 5560 Hudson blvd., N. Bergen
 *Schwarz, W. J. A., 269 Cator av., Jersey City
 Sciorsci, Edw. P., 609 Bloomfield st., Hoboken
 Scott, Samuel G., 141 Bergen av., Jersey City
 Selinger, S., 413 16th st., West New York
 Sena, Marie, 303 Anderson av., Fairview
 Sesta, Jos., 242 Fulton av., Jersey City
 Sexsmith, George H., 719 Ave. C, Bayonne
 Shapiro, Maurice, 750 Ave. C, Bayonne
 Shapiro, N. J., 192 Palisade av., Union City
 Sheeran, Vincent J., 269 Jewett av., Jersey City
 Shipman, Frank C., 3663 Boulevard, Jersey City
 Shulman, N. L., 538 45th st., Union City
 Siegler, Julius, 646 Bergen av., Jersey City
 Simeone, Peter A., 555 38th st., Union City
 Sirken, Chas., 887 Summit av., Jersey City
 Smith, Alex. L., 2672 Boulevard, Jersey City
 Snyder, J. E. C., 1023 Garden st., Hoboken
 Spalding, H. J., 512 45th st., Union City
 Spano, Frank, 320 47th st., Union City
 Spath, George, 722 Hudson st., Hoboken
 Spence, Henry, 2540 Blvd., Jersey City
 Sprague, Seth B., 301 York st., Jersey City
 Steadman, E. T., 107 Christopher st., Montclair
 Stein, Jacob M., 68 Columbia ter., Weehawken
 Stockfish, Robt., 3644 Boulevard, Jersey City
 Stout, J. P., 165 Jewett st., Jersey City
 Street, D. B., 27 Woodlawn av., Jersey City
 Stuart, William C., 518 Hudson st., Hoboken
 Sullivan, George F., 510 Hudson st., Hoboken
 Sullivan, James A., 668 Jersey av., Jersey City
 Sullivan, Margaret N., 70 Undercliffe rd., Montc'r
 Sulouff, S. Henry, 662 Newark av., Jersey City
 Sweeney, William J., 68 Clifton ter., Weehawken
 Swiney, Merrill A., 325 Ave. C, Bayonne
 Tataryan, H., 422 New York av., Union City
 Temes, J. Howard, 293 Ege av., Jersey City
 Thum, Ernest, 819 Ave. C, Bayonne
 Tidwell, H. F., 229 16th st., West New York
 Timlin, James W., 64 Beech st., Arlington
 Trehwella, Arthur P., 800 Montgomery st., Jer. C'y
 Tyndall, Hugh H., 83 Highwood ter., Weehawken
 Urevitz, Abraham, 495 New York av., Union City
 Varriano, John L., 3258 Boulevard, Jersey City
 Visconti, Jos. A., 711 Garden st., Hoboken
 von Deesten, Henry T., 268 Palisade av., Jer. C'y
 Vostrosablin, Nicholas A., 121 Grand st., Jer. City
 Vreeland, Hamilton, 232 S. Irving st., Ridgewood
 Vreeland, William N., 32 Bergen av., Jersey City
 Ward, John V., 438 Palisade av., Weehawken

HUDSON COUNTY—Continued

Waters, Edward G., 39 Gifford av., Jersey City
 Watman, Anthony J., 2761 Boulevard, Jersey City
 Weber, Walter D., 305 23rd st., Union City
 Wechsler, Joseph, 3342 Boulevard, Jersey City
 Weiss, Abraham, 456 Palisade av., Weehawken
 Weiss, M. J., 734 Ave. C., Bayonne
 Welcher, H. A., 5446 Hudson Boulevard, N. Bergen
 Wheeler, James A., 85 Van Reypen st., Jer. City
 White, Hugh M., 901 Summit av., Jersey City
 White, Thomas J., 221 Union st., Jersey City
 Wilcox, Frank A., 415 16th st., West New York
 Wilkinson, George, 144 Old Bergen rd., Jer. City
 Williamson, W. L., 22 West 22nd st., Bayonne
 Willis, John, 268 Palisade av., Jersey City
 *Winter, Daniel T., Jr., 8 Gifford av., Jersey City
 Woelfle, Henry E., 69 Sherman pl., Jersey City
 Woodruff, S. R., 16 Enos pl., Jersey City
 Yeaton, W. L., 204 11th st., Hoboken
 Yudkoff, Wm., 403 Boulevard, Bayonne
 Zenneck, J. F., 17 Fourth st., Weehawken
 Zitani, Alfred M., 937 Washington st., Hoboken

Associate Members

Ajamian, Harry M., 509 36th st., Union City
 Amdur, Louis A., 834 Westside av., Jersey City
 Aranowitz, H. T., 11 E. 42 nd st., Bayonne
 Barone, Francis A., 175 Fulton st., Jersey City
 Bergen, Marshall, 273 Bergen av., Jersey City
 Cowan, Joseph H., 85 Van Reypen st., Jersey City
 De Fusco, G. T., 330 Newark av., Jersey City
 Driscoll, Raymond, 919 Boulevard, Bayonne
 Faber, Edward, 101 Wegman Pkwy., Jersey City
 Federer, John F., 821 Blvd. East, Weehawken
 Fialk, Harry, 996 Hudson av., Union City
 Frank, Nathan, 186 Bowers st., Jersey City
 Frieman, Hyman, 744 Ave. C, Bayonne
 Gariboldi, Louis, 1016 Hudson Blvd., Hoboken

Ghee, Peter F., 734 Ocean av., Jersey City
 Goldowsky, Ira, 1866 Boulevard, Jersey City
 Gutman, Edwin K., 980 Summit av., Jersey City
 Jaffee, Benjamin, 568 Bergen av., Jersey City
 Jenson, Grover H., 169 Lexington av., Jersey City
 Kimmel, Seymour, 558-A Jersey av., Jersey City
 Kraemer, Samuel H., 309 Baldwin av., Jersey City
 Leir, J. Krevin, 9 Garrison av., Jersey City
 Lisanti, G., 660 Tyler pl., West New York
 Lynn, Irving I., 272 Barrow st., Jersey City
 Madison, Louis K., 358 Pacific av., Jersey City
 Mulvihill, Wm. J., 275 Hudson Blvd., Bayonne
 Ortolano, Jas., 522 Garden st., Hoboken
 O'Sullivan, John R., 288 Chestnut st., Kearny
 Penchansky, Samuel, 847 Ave. C, Bayonne
 Piltz, George F., 153 25th st., Guttenberg
 Sacco, Gregory A., 440 New York av., Union City
 Sandler, Samuel, Trust Co. Bldg., Jersey City
 Singer, Sina S., 1969 Blvd., Jersey City
 Taft, Herman L., 25 Liberty pl., Weehawken

Honorary Members

Cropper, C. W., 2540 Boulevard, Jersey City

Resignations

Dennis, Louis A., Red Bank

Transfers

Core, Edwin H., to Norton-Decatur Co. Soc., Kan.
 Vitale, Dominic V., to Union County Society
 Lucas, Fred W., to Burlington County Society
 Bartlett, Walter P., to Fairfield County Society

Number of active members and basis of representation, 388, March 15, 1934.

Associate members, 34.

*Deceased.

HUNTERDON COUNTY (10)

Society organized June 12, 1821. Meets fourth Tuesday in January, April, July and October. Annual meeting in October.

President

McCorkle, W. E., Ringoes

First Vice-President

Thomas, F. Ashley, Flemington

Second Vice-President

Boothby, I. Roland, Glen Gardner

Secretary

Fuhrmann, Barclay S., Flemington

Treasurer

Closson, Edward W., Lambertville

Reporter

Fuhrmann, Barclay S., Flemington

Censors

Tompkins, G. B.
 Coleman, A. H.
 Eng'ish, S. B.

Baker, Philip W., High Bridge
 Boothby, I. R., Glen Gardner
 Chamberlain, John L., Sergeantsville
 Christensen, A. H., Lebanon
 Clark, Frank G., White House Station
 Closson, Edward W., Lambertville

Coleman, A. H., Clinton
 English, Samuel B., Glen Gardner
 Fuhrmann, Barclay Stokes, Flemington
 Fulper, Theodore B., Hampton
 Gramsch, Louis A., Glen Gardner
 Harmon, Harry M., Frenchtown
 Harner, M. H., High Bridge
 Heil, A. Arling, Milford
 Henry, George, Flemington
 Knox, Howard A., High Bridge
 Lane, E. W., Bloomsbury
 Morrison, J. Bennett, Newark
 McCorkle, W. E., Ringoes
 Slavin, Paul, Glen Gardner
 Thomas, Floyd A., Flemington

Resigned

Salmon, L. T., Lambertville
 Williams, L. C., Lambertville

Honorary Members

Ely, Lancelot, Somerville
 Haussling, Francis R., Newark
 Marsh, Elias J., Paterson
 Newcomb, Marcus W., Browns Mills
 Quigley, Frederic J., Union City
 Scammel, Frank C., Trenton
 Sommer, George N. J., Trenton

Number of active members and basis of representation, 20, March 15, 1934.

MERCER COUNTY (11)

Society organized May 23, 1848. Meets second Wednesday of each month except July, August and September. Annual meeting in December.

President

Connelly, John A., Trenton

Vice-President

Cottone, R. J., Trenton

Secretary

Hutchinson, A. Dunbar, Trenton

Treasurer

North, Harry R., Trenton

Reporter

Hutchinson, A. Dunbar, Trenton

Censors

Seely, R. B., Trenton

Mitchell, Chas. H., 1100 West State st., Trenton

Schauffler, William G., Princeton

Abey, W. J. H., 23 N. Delaware av., Pennington

Ackley, David B., 21 N. Clinton av., Trenton

Adams, Chas. F., 34 W. State st., Trenton

Applegate, Edw. T. R., 1125 Greenw'd av., Trent'n

Applestein, Robert, 569 E. State st., Trenton

Aronis, H. R., 239 E. Hanover st., Trenton.

Ashley, H. H., 192 W. State st., Trenton

Atkinson, Alvan W., 423 E. State st., Trenton

Barrows, Arthur M., 440 Hamilton av., Trenton

Barry, R. G., 807 W. State st., Trenton

Beairto, E. B., 178 W. State st., Trenton

Belford, R. J., 1st Nat. Bank Bldg., Princeton

Bellis, Horace D., 437 E. State st., Trenton

Belting, Arthur W., P. O. Box 1215, Trenton

*Bergen, E. R., Princeton

Berger, Harry, 921 Clinton av., Trenton

Berman, Jacob J., 409 Market st., Trenton

Blackwell, Enoch, Trenton Trust Bldg., Trenton

Blaugrund, Samuel, 190 W. State st., Trenton

Blum, Joseph M., 128 Mill st., Trenton

Bowman, A. K., 272 Nassau st., Princeton

Buckley, R. T., Peddie School, Hightstown

Burroughs, Edmund W., 701 W. State st., Trenton

Carroll, C. Walter, 117 Centre st., Trenton

Carnoll, W. V., 211 Academy st., Trenton

Chianese, C. Chester, 464 Hamilton av., Trenton

Child, Florence C., 317 City Hall, Trenton

Cohen, C. C., 217 W. Hanover st., Trenton

Cohen, Herman, 1160 Hamilton av., Trenton

Cohen, Wm., 1007 Greenwood av., Trenton

Collier, Wm. S., 1000 S. Broad st., Trenton

Collins, Henry J., 1160 Hamilton av., Trenton

Comfort, John B., 50 S. Clinton av., Trenton

Connelly, John A., 212 W. State st., Trenton

Corio, Geo. A., 309 Clinton av., Trenton

Corrigan, Patrick H., 1720 Broad st., Trenton

Costill, Henry B., 371 Hamilton av., Trenton

*Cotton, Henry A., State Hospital, Trenton

Cottone, R. J., 683 Princeton av., Trenton

Cowlbeck, H. D., 224 W. State st., Trenton

Cox, Harold G., Hightstown

*Crane, J. Welling, State Prison, Trenton

D'Arcy, Walter E., 545 E. State st., Trenton

Davis, Harold L., 178 W. State st., Trenton

Davison, Royden W., 205 W. State st., Trenton

Denelsbeck, J. Otis, 878 E. State st., Trenton

Doranz, H. K., 38 S. Hermitage av., Trenton

Douress, Philip C., 802 E. State st., Trenton

Elias, Elmer J., 827 S. Broad st., Trenton

Epstein, Harry H., 225 Perry st., Trenton

Ernest, Richard B., 240 W. State st., Trenton

Farmer, W. D., Allentown

Fee, Elam K., Lawrenceville

Fell, Alton S., 529 E. State st., Trenton

Fessler, A. J., 1544 S. Broad st., Trenton

Finegan, P. J., 752 Greenwood av., Trenton

Franklin, C. C., 1012 Hamilton av., Trenton

Friedman, M. H., 526 N. Clinton av., Trenton

Friedmann, Leonard L., 484 Princeton av., Tr'nt'n

Fuchs, Jacob N., 1267 S. Broad st., Trenton

Funkhouser, Edgar B., State Hospital, Trenton

Goldberg, Benjamin M., 1156 E. State st., Trent'n

Gordon, Clark H., 808 E. State st., Trenton

Graham, E. E., P. C. Box 195, Yardsville

Guglielmelli, A. D., 449 Hamilton av., Trenton

Haggerty, Daniel L., 227 N. Warren st., Trenton

Haney, John J., 167 Cooper st., Trenton

Harman, J. R., 1819 S. Broad st., Trenton

Harman, Wm. J., 740 W. State st., Trenton

Hidden, J. C., 199 Nassau st., Princeton

Hirschfield, B. A., 1404 Greenwood av., Trenton

Holland, John A., 190 W. State st., Trenton

Hunter, F. D., Hamilton Square, Trenton

Hutchinson, A. D., 913 W. State st., Trenton

Hutchinson, G. F., Hamilton Square, Trenton

Iams, Samuel H., 34 Mercer st., Princeton

Ireland, A. G., N. J. Dept. Education, Trenton

Ivins, Wm. C., 214 E. Hanover st., Trenton

Jaspan, Samuel C., 280 Division st., Trenton

Kachdorian, Vartan, 930 Brunswick av., Trenton

*Kent, Morton M., 233 N. Warren st., Trenton

Koplin, Nathan H., 142 W. State st., Trenton

Kuhl, Paul E., 48 N. Clinton av., Trenton

Kustrup, J. F., 1435 S. Broad st., Trenton

Lavine, Barney D., 630 N. Clinton av., Trenton

Lettiere, A. J., 320 Centre st., Trenton

Levin, Louis, 140 W. State st., Trenton

Little, William R., 493 W. State st., Trenton

MacDermid, Lynden E., Bordentown

MacFarland, Burr W., Broad St. Bk. Bldg., Tr'nt'n

McCandless, W. K., State Hospital, Trenton

McCullough, John H., 523 E. State st., Trenton

*McDonald, John O., 194 W. State st., Trenton

McGuigan, F. A., 212 N. Warren st., Trenton

McGuire, Jas J., 122 W. State st., Trenton

Majeski, H. J., 1015 Brunswick av., Trenton

Marotte, Chas. L., 1417 Clinton av., Trenton

Means, P. B., State Hospital, Trenton

Meriwether, E. G., N. J. State Hospital, Trenton

Mewborne, Edw. B., Lawrenceville

Miller, Earle K., 2502 Nottingham way, Trenton

Miller, G. H., Cranbury

Mitchell, Chas. H., 1100 W. State st., Trenton

Mitskas, T. V. J., Crosswicks

Moriconi, A. F., 438 Hamilton av., Trenton

Mras, J. N., State Hospital, Trenton

Murphy, J. A., 467 Hamilton av., Trenton

North, Harry R., 160 W. State st., Trenton

*Oliphant, N. B., 152 W. State st., Trenton

O'Rourke, James J., 871 Stuyvesant av., Trenton

Pantaleone, Joseph, 504 Hamilton av., Trenton

Parker, H. Norton, 72 N. Clinton av., Trenton

Pessel, J. F., 224 W. State st., Trenton

Peterson, W. R., 224 W. State st., Trenton

Phillips, Robert H. C., 144 W. State st., Trenton

Pierson, Carl L., 938 W. State st., Trenton

Pierson, J. R., 224 W. State st., Trenton

Pierson, Theodore A., Hopewell

Potter, Ellen C., Glen Cairn Arms, Trenton

MERCER COUNTY—Continued

Powis, Ethel M., 198 W. State st., Trenton
 Poyas, M. L., 198 W. State st., Trenton
 Proctor, Francis E., 1245 Greenwood av., Trent'n
 Purcell, Ernest F., 800 Stuyvesant av., Trenton
 Ragany, Joseph, 966 S. Broad st., Trenton
 Rainey, W. G., 20 Nassau st., Princeton
 Rogers, Alvin S., 126 N. Warren st., Trenton
 Rogers, Lawrence H., Municipal Colony, Trenton
 Rogers, W. N., 1255 Brunswick av., Trenton
 Rowan, Henry M., 224 W. State st., Trenton
 Scammell, Frank G., 40 S. Clinton av., Trenton
 Scasserra, B. B., 110 Nassau st., Princeton
 *Schauffler, Wm. G., 21 Morven pl., Princeton
 Schildkraut, Jacob M., 170 W. State st., Trenton
 Schroeder, H. J. L., 134 W. State st., Trenton
 Seeley, Roy B., 78 N. Clinton av., Trenton
 Seitzick, Hannah E., 733 Hamilton av., Trenton
 Sekerak, Albert J., 977 S. Broad st., Trenton
 Shaw, Jos. B., 119 S. Warren st., Trenton
 Sica, Samuel, 431 E. State st., Trenton
 Sill, John B., 942 W. State st., Trenton
 Silver, E. Drew, Hightstown
 Silver, George A., Hightstown
 Sinton, John Y., Imlaystown
 Sista, Chas. R., 476 Hamilton av., Trenton
 Slack, Clarence J., 230 W. State st., Trenton
 Smith, Houghton, 1063 S. Clinton av., Trenton
 Smith, W. Henley, 34 W. State st., Trenton
 Sommer, Geo. N. J., 120 W. State st., Trenton
 Stein, L. A., 205 Market st., Trenton
 Stone, R. G., State Hospital, Trenton
 Summers, A. D., 180 Nassau st., Princeton
 Swern, Nathan, 130 W. State st., Trenton
 Taylor, Walter A., 450 Rutherford av., Trenton
 Treiber, Benj. A., 626 Perry st., Trenton

Turner, Irvine F. P., 224 W. State st., Trenton
 Vaczi, Stephen, 983 S. Broad st., Trenton
 Van Neste, George V., Hopewell
 Vanneman, Joseph S., 180 Nassau st., Princeton
 Walsh, Thomas J., 1158 E. State st., Trenton
 Warter, P. J., 626 W. State st., Trenton
 Waters, Chas. H., 928 W. State st., Trenton
 Watson, Fred S., 233 W. State st., Trenton
 Watts, Wilbur, 436 E. State st., Trenton
 West, Edgar L., 443 E. State st., Trenton
 Weisler, Howard, 491 Centre st., Trenton
 Wikoff, J. L., 799 Pennington av., Trenton
 Wilbur, William Lane, Hightstown
 Williams, Geo. W., 217 N. Warren st., Trenton
 Williams, Harry D., 527 E. State st., Trenton
 Wright, Howard E., P. O. Box 276, Princeton
 Yaeger, Leslie A., 470 Hamilton av., Trenton
 Yazujian, Dikran M., 562 E. State st., Trenton
 Zandt, Frederick B., Hamilton sq., Trenton
 Zimskind, Joshua N., 210 W. State st., Trenton

Honorary Members

Bergen, Elston H., Princeton
 Bruyere, Abel T., Trenton
 Clark, Wm. A., Trenton
 Maclaren, Wm. S., Princeton
 Moore, R. H., Trenton

100 per cent paid up membership, March 15, 1934.

Number of active members and basis of representation, 168.

*Deceased.

MIDDLESEX COUNTY (12)

Society organized June 11, 1816. Meets third Wednesday afternoon of each month, September to June, inclusive. Annual meeting in December.

President

Mark, Joseph S., Woodbridge

Vice-President

Haywood, Harry, New Brunswick

Secretary

Klein, Edward F., Perth Amboy

Treasurer

Smith, Marshall, New Brunswick

Reporter

Hilker, George F., Perth Amboy

Anderson, John F., 195 College av., N. Brunswick
 Applegate, Grov. T., 71 Livingston av., N. Br'ns'w'k
 Avery, Phillip S., Middl's'x Gen. Hosp., N. Bruns.
 Basset, Lavern C., 320 New Market rd., Dunellen
 Beekman, Jesse H., Sayreville
 Berkow, Samuel G., 138 Market st., Perth Amboy
 Boulden, George P., P. O. Box 5, Dunellen
 Breslow, S., 111 Market st., Perth Amboy
 Brody, Morton J., 84 Bayard st., New Brunswick
 Brown, Fred L., 67 Livingston av., N. Brunswick
 Burnett, Chas. B., Main st., South River
 Calvin, Charles, 80 Commerce st., Perth Amboy
 Carroll, Edgar, Main st., Dayton
 Clarke, F. W., New st., New Brunswick
 Coble, Morris S., 102 Wash. st., Perth Amboy

Cohen, N. B., 232 State st., Perth Amboy
 Collins, James J., Main st., Woodbridge
 Cooper, I. J., 90 Livingston av., New Brunswick
 Cottrell, Judson G., 159 Market st., Perth Amboy
 Csema, E. J., 151 Somerset st., New Brunswick
 Dieker, Howard, 78 Main st., South River
 Fagan, Jas. L., 51 Bayard st., New Brunswick
 Fanelli, Antonio, 469 Lowrie st., Perth Amboy
 Faulkingham, R. J., 61 Liv'gston av., N. Bruns.
 Feher, L. A. M., 196 Somerset st., N. Brunswick
 Fine, H. P., 185 Market st., Perth Amboy
 Fishkoff, A., 360 State st., Perth Amboy
 Fithian, Geo. W., 266 High st., Perth Amboy
 Forney, Norman N., Main st., Milltown
 Fox, S. W., Ford av., Fords
 Gauzza, Valentine P., Fords
 Goldberg, L., 303 N. Washington av., Dunellen
 Grieve, James, 88 Market st., Perth Amboy
 Gutmann, Benjamin, 51 Livingston av., N. B'w'k
 Gutowski, Jos. M., 433 Brace av., Perth Amboy
 Haight, Harry W., Raritan av., New Brunswick
 Haywood, Harry, 3 Elm row, New Brunswick
 Hilker, G. F., 463 State st., Perth Amboy
 Hinton, S. H., Parlin
 Hoffman, Florentine M., 91 Bay'd st., N. Bruns.
 Howell, E. G., New st., New Brunswick
 Howley, Barth M., 419 George st., N. Brunswick
 Hunt, A. C., 625 Middlesex av., Metuchen
 Hunt, Melvin M., 16 Jackson st., South River
 *Johnson, Frank C., 51 Livingston av., N. Bruns.
 Karshmer, Nathan, 422 George st., N. Brunswick

MIDDLESEX COUNTY—Continued

Kemeny, Imre, Carteret

Kinney, Seldon T., 250 Main st., South Amboy

Kleiber, Estella, 139 New st., New Brunswick

Klein, Edward F., 136 Market st., Perth Amboy

Klein, William, 85 Bayard st., New Brunswick

Kler, J. H., Reed st., Stelton

Koelsch, F. J., Bayard st., New Brunswick

Kovarsky, A. E., 255 State st., Perth Amboy

Kraczyk, M. J., 207 Whitehead av., New Bruns.

Kramer, S. E., 121 Market st., Perth Amboy

Kunschner, A. J., Milltown

Leonard, Geo. F., 63 N. 5th av., New Brunswick

London, William M., 256 State st., Perth Amboy

Long, Pauline A., 20 Liv'gston av., New Brunswick

Longbothum, George T., 208 Dun'll'n av., Dunell'n

Lund, John L., 267 High st., Perth Amboy

MacDowell, J. L., 112 State st., Perth Amboy

McCormick, Wm. H., 266 M'k't st., Perth Amboy

McGovern, John F., 24 Livingston av., N. Bruns.

McKiernan, Robt. L., 97 Bayard st., N. Bruns'k

McKinstry, J. W., Jamesburg

McLeod, N. S., Raritan av., Highland Park

Macham, Eugene A., 112 Stevens av., S. Amboy

Mann, Jacob J., 255 State st., Perth Amboy

Mark, Joseph, 102 Green st., Woodbridge

Marvin, Dorothy, 51 Livingston av., N. Bruns'k

Meinzer, Martin S., 147 Market st., Perth Amboy

Merrill, C. F., 16 So. 3d av., H'ghl'd P'k, N. Bruns.

Messinger, Samuel J., Chrome

Morris, Carlyle, Metuchen

Nafey, Herbert W., 51 Livingston av., N. Bruns.

Nauky, Chas. W., Jr., 403 High st., Perth Amboy

Nieman, S. V., 92 Bayard st., New Brunswick

Pansy, Abraham A., 12 Jackson st., South River

Platt, Thomas H., 208 Dunellen av., Dunellen

Reason, John J., Roosevelt

Rona, Maurice, 159 Bayard st., New Brunswick

Rothschild, K., 49 Bayard st., New Brunswick

Rowland, John H., 159 New st., New Brunswick

Runyon, Lawrence P., 82 Somerset st., N. Br'w'k

Sandella, J. F., 169 New st., New Brunswick

Scott, Fred W., 103 Bayard st., New Brunswick

Sender, Fannie, 191 Whitehead st., South River

Sherman, W. E., George & Schureman, N. Br'w'k

Silk, Chas. I., 189 Rector st., Perth Amboy

Sirott, Barnett H., 409 State st., Perth Amboy

Slobodien, Benjamin F., 107 Market st., P. Amboy

Smith, A. L. M., 62 Bayard st., New Brunswick

Smith, J. Vincent, 463 State st., Perth Amboy

Spencer, Ira T., Main st., Woodbridge

Steffen, Charles T., Dunellen av., Dunellen

Stillwell, H. C., 70 Irving pl., Rahway

Strandberg, H., 94 Washington av., Carteret

Sullivan, Chas. J., 57 Paterson st., N. Brunswick

Swift, Edw. M., 400 Division st., Perth Amboy

Taber, F. H., 3 Elm row, New Brunswick

Toy, Calvert R., 92 Bayard st., New Brunswick

Tyrrell, George W., 380 State st., Perth Amboy

Urbanski, Admian X., 148 Market st., P. Amboy

Urbanski, Matt. F., 314 Washington st., P. Amboy

Van Dyke, Benjamin S., Cranbury

Voorhees, Howard C., 43 Bayard st., N. Bruns'k

Walker, R. B., 108 Church st., New Brunswick

Weber, J. Francis, 264 Main st., South Amboy

Wetterberg, Louis F., 389 School st., Woodbridge

Wilentz, Wm. C., 188 Market st., Perth Amboy

Wilson, John G., 280 High st., Perth Amboy

Witmer, J. D., Metuchen

Associate Members

Horoschak, Anna, Woodbridge

Klein, Alexander, 210 Market st., Perth Amboy

Lazow, S. M., Broad st., Matawan

Moletch, Matthew, Jamesburg

Rineberg, I. E., 93 Bayard st., New Brunswick

Stein, William, 71 Livingston av., New Brunswick

Transferred

Erwin, Millard, Middlesex to Essex Co.

Japhe, N., Middlesex to Essex Co.

Wright, E. T., Middlesex to Atlantic Co.

Number of active members and basis of representation, 113, March 15, 1934.

Number of Associate Members, 6.

*Deceased.

MONMOUTH COUNTY (13)

Society organized July 24, 1816. Meets last Wednesday of each month, October to June, inclusive. Annual meeting on the Tuesday after the first Monday in December.

President

Maher, John E., Long Branch

Vice-President

Fairbanks, W. H., Freehold

Secretary-Treasurer

Featherston, D. F., Asbury Park

Reporter

Edelson, Samuel, Neptune

Censors

Clayton, John C., Freehold

Hausman, Samuel W., Red Bank

Villapiano, Jos. G., Asbury Park

Ackerman, Jas. F., 1010 Grand av., Asbury Park

Ackerman, Joseph, 404 Asbury av., Asbury Park

Albright, Louis F., 210 Madison av., Spring Lake

Altschul, Frank Jos., 177 Garfield av., L. Branch

Appleton, Ralph, Farmingdale

Baeseman, R. W., 501 Grand av., Asbury Park

Baker Elsworth F., State Hospital, Marlboro

Becker, Sidney, Keyport

Binder, Joseph, 149 Garfield av., Long Branch

Blaisdel, C. Byron, 489 Broadway, Long Branch

Boyd, John, East Front st., Red Bank

Brown, Harvey S., 5 Club pl., Freehold

Brown, Kenneth, 603 Asbury av., Asbury Park

Bulwinkle, Frederick, Ocean Blvd., Atl. Highlands

Campbell, Wm. K., 96 3rd av., Long Branch

Cassidy, S. H., Osborn st., Keyport

Clayton, John C., 73 W. Main st., Freehold

DePons, S. C., 501 Grand av., Red Bank

Donovan, William F., Brielle

Edelson, Samuel, 1141 Corlies av., Neptune

Ellenson, S. S., 507 4th av., Asbury Park

Fairbanks, Warren H., 27 Broadway, Freehold

Featherston, Daniel F., 506 4th av., Asbury Park

Feinberg, Harry D., 384 2d av., Long Branch

Fenton, Tennesse E., 320 Ludlow av., Spring Lake

MONMOUTH COUNTY—Continued

Fisher, James A., 501 Grand av., Asbury Park
 Friedman, H. H., 63 W. Main st., Freehold
 Gesswein, Carl A., Church st., Keyport
 Glazer, Edward, 501 Grand av., Asbury Park
 Goff, Frank J., 64 Maple av., Red Bank
 Gordon, J. B., N. J. State Hosp., Marlboro
 Gosling, W. W., 23 Monmouth av., Red Bank
 Graves, Charles, State Hospital, Marlboro
 Gullium, W. H., 505 Fourth av., Asbury Park
 Haines, Emerson S., 501 Grand av., Asbury Park
 Hausman, Samuel W., 50 W. Front st., Red Bank
 Heatley, William, 335 Broad st., Red Bank
 Herrman, Wm. G., 501 Grand av., Asbury Park
 Hill, J. A., 511 Cedar av., Allenhurst
 Holters, Otto R., 515 2d av., Asbury Park
 Hunt, Geo. Halsey, 136 Broad st., Red Bank
 Hyer, Oscar H., 113 Main st., Matawan
 Ingling, Harry W., 51 W. Main st., Freehold
 Jamison, W. F., 501 Grand av., Asbury Park
 Jones, Granville L., N. J. State Hosp., Marlboro
 Jordan, J. C., 238 E. Main st., Manasquan
 Kazman, Harold A., 406 Broadway, Long Branch
 Leighton, Robt. L., 401 Ludlow av., Spring Lake
 Leonard, Lothair L., 615 Asbury av., Asbury Park
 MacKenzie, R. A., 501 Grand av., Asbury Park
 Maher, John E., 90 Third av., Long Branch
 Makin, John B., 501 Grand av., Asbury Park
 Mason, Howard B., 90 W. Main st., Freehold
 Mathews, William, 65 Broad st., Red Bank
 Moffatt, Barclay W., Nut Swamp rd., Red Bank
 Neiderhoffer, S. L., 189 Monmouth rd., Oakhurst
 Nichols, Stanley H., 501 Grand av., Asbury Park
 Niemtzw, Frank, 45 E. Main st., Freehold
 Opferman, J. L., 167 Bay av., Highlands
 Parry, O. K., 601 Bangs av., Asbury Park
 Podell, Alfred, 51 E. Front st., Red Bank
 Pons, C. A., 501 Grand av., Asbury Park
 Pregnall, James P., 501 Grand av., Asbury Park
 Prout, Charles, 406 6th av., Asbury Park
 Quirk, Martin A., 104 Maple av., Red Bank

Reynolds, G. G., 64 W. Main st., Freehold
 Robinson, William A., 62 Main av., Ocean Grove
 Rosenthal, A., 38 Mount st., Atlantic Highlands
 Rowland, James J., 321 Bay av., Highlands
 Rubin, A. David, 401 1st av., Asbury Park
 Rullman, Walter, 50 W. Front st., Red bank
 Sayre, William D., 69 Maple av., Red Bank
 Schmidt, Albert F., 81 Union av., Manasquan
 Scott, E. A., Belle Mead San., Belle Mead
 *Shaw, Harry English, Long Branch
 Slocum, Harry B., Bath av., Long Branch
 Stevenson, Geo. S., Red Bank
 Strahan, F. G., 473 Broadway, Long Branch
 Straughan, C. C., 23 Monmouth st., Red Bank
 Strauss, Arthur, 130 Pavil. av., Long Branch
 Traverso, Daniel, 705 D st., Belmar
 Trippe, C. M., 702 Asbury av., Asbury Park
 Upham, Helen T., 305 Third av., Asbury Park
 Villapiano, Jos. G., 706 Mattison av., Asbury Park
 Von Oehsen, W. H., 409 Fifth av., Bradley Beach
 Wallin, Alfred C., 195 Main st., Matawan
 Watkins, Robert E., 517 5th av., Belmar
 Weiner, Joseph, 601 Bangs av., Asbury Park
 Wilbur, Franklin L., 504 Asbury av., Asbury P'k
 Wilson, R. B., 86 Broad st., Red Bank
 Wise, Lester D., 119 Morris av., Long Branch
 Woronoff, Murray, 130 Main st., Keyport

Honorary Members

Beach, E. M., Long Branch
 Havens, W. P., Farmingdale

Resigned

Dorr, Harry B., Ocean Grove

Number of active members and basis of representation, 91.

100 per cent paid up March 15, 1934.

*Deceased.

MORRIS COUNTY (14)

Society organized June 11, 1816. Meets on second Tuesday of March, June, September and December. Special meetings (1-3 yearly) arranged by Executive Committee. Annual meeting in September.

President

Frost, Inglis F., Morristown

Vice-President

McMahon, Bernard C., Morristown

Secretary

Ward, Albert J., Morristown

Treasurer

Young, George J., Morristown

Reporter

Curry, Marcus A., Greystone Park

Historian

Kice, H. W., Wharton

Executive Committee

The Officers and
 Larson, Henry M., Morristown
 Pinckney, Frank H., Morristown
 Williams, Louis E., Madison

Abel, Elvira Dean, Morristown
 Ackerman, Edward, Dover
 Baker, Augustus L., 389 W. Blackwell av., Doven
 Beaver, Jennie Dean, 8 Oliphant Park, Morrist'n
 Bird, Frank L., Netcong
 Booth, Wm. K., Boonton
 Carberry, Edw. T., Wharton
 Chilton, F. S., Pompton Plains
 Christian, Thomas B., Greystone Park
 Collins, Lawrence M., Greystone Park
 Comeau, George, Morris Plains
 Costello, William Francis, Dover
 Coultas, A. B., Madison
 Curry, Marcus A., Greystone Park
 Deichman, Charles H., Morristown
 Donovan, J., Greystone Park
 Eckhardt, Ralph A., Madison
 Emory, George B., 1 Franklin pl., Morristown
 Falvello, N. A., Morristown
 *Farrow, J. Willard, Dover
 Frost, Inglis F., 26 Maple av., Morristown
 Galasso, Attilio, 275 Speedwell av., Morristown
 Geary, Daniel J., Morristown
 Gibb, W. Blake, Madison
 Gilbertson, R. L., Madison

MORRIS COUNTY—Continued

Glazebrook, Francis H., 6 Altmont ct., Morristown
 Gordon, Charles D., Mt. Arlington
 Graddick, Lester W., Morristown
 Gregory, Marie F., Green Village rd., Madison
 Harrington, J. Henry, Rockaway
 Hatch, H. S., Morristown
 Haven, Samuel C., 14 Elm st., Morristown
 Heinig, Frank G., Boonton
 Hubert, Antonio, 133 Main st., Rockaway
 King, Alden P., Dover
 Krauss, Fletcher I., Chatham
 Kuite, George B., Morris Plains
 Larson, Henry M., 36 Franklin st., Morristown
 Lathrope, Geo. H., 965 Broad st., Newark
 McElroy, Ervin, Rockaway
 McMahon, Bernard C., Morristown
 Mathews, R., Morristown
 Mial, Leonidas L., 38 Elm st., Morristown
 Michell, George, 221 High st., Hackettstown
 Mills, Clifford, Morristown
 Musetto, Carmelo A., Boonton
 *Owen, Fred W., 18 Franklin pl., Morristown
 Pinckney, Frank H., Morristown
 Plume, Clarence A., Succasunna
 Pottinger, W., Mountain Lakes
 Prager, Bert A., Chatham
 Reed, F. Grendon, 52 Hill st., Morristown
 Schmidt, Hilmar R., Lincoln Park

Schmitz, Mathias, Denville
 Scott, Harold R., Morristown
 Seward, Wm. H., Madison
 Sherman, Byron G., Maple av., Morristown
 Smith, M. K., Morristown
 Spencer, Alvin, 19 E. Blackwell st., Dover
 Sutphen, E. Blair, 26 Maple av., Morristown
 Teller, D. W., Morristown
 Teskey, Stanley, 10 Anderson rd., Bernardsville
 Thomas, Thomas S., 135 South st., Morristown
 Troedsson, Bror S., Mendham
 Truax, Alfred J., Boonton
 Voorhies, Wm. S., Mendham
 Washburn, Philip C., Greystone Park
 *Wigg, Cuthbert, Boonton
 *Wolfe, W. J., 55 Fairmount av., Chatham
 Young, George J., 208 Morris av., Morristown

Honorary Members

Cooper, E. P., Parsippany
 Kice, H. W., Wharton
 *Wigg, C., Boonton

Number of active members and basis of representation, 66, March 15, 1934.

*Deceased.

OCEAN COUNTY (15)

Society organized October 28, 1903. Meets in May and November as called by the Secretary. Annual meeting in November.

President

Goldstein, Abraham, Lakewood

Vice-President

Woodhouse, Alfred, Toms River

Secretary

Hayden, W. G., Toms River

Treasurer

Brouwer, Frank, Toms River

Reporter

Herbener, E. G., Lakewood

Brouwer, Frank, Toms River
 Buermann, Robert, Lakewood
 Bunnell, Frederick N., Barnegat
 Carmona, Louis R., Tuckerton
 Davies, William W., Naval Air Station, Lakewood

Disbrow, Harold B., Lakewood
 Disbrow, Vanderhoof M., Lakewood
 Dodd, Wm. E., Beach Haven
 Goldstein, A., Lakewood
 Halbach, Robert, 513 Main st., Toms River
 Hayden, W. G., 412 Main st., Toms River
 Herbener, E. G., Lakewood
 Lemacher, Frank, Lakewood
 Obert, J. E., New Egypt
 Ripley, Charles D., 11 Lincoln Park, Newark
 Swan, Guy H., Beachwood
 Thomson, T. F., Lakewood
 Tobin, Adolph, Lakewood
 Woodhouse, Alfred, Toms River

Honorary Members

Jones, R. R., Toms River

Number of active members and basis of representation, 19, March 15, 1934.

*Deceased

PASSAIC COUNTY (16)

Society organized January 14, 1844. Meets the second Thursday evening of each month except June, July and August. Annual meeting in October.

President

Willard, Harry S., Paterson

First Vice-President

MacMillan, Wright, Passaic

Secretary

Hall, Wayne W., Paterson

Treasurer

Taber, Leslie, Paterson

Reporter

Johnsen, S. W., Passaic

Censors

Carlisle, John H., Passaic
 Morrill, J. P., Paterson
 Roemer, Jacob, Paterson

Allen, J. M., 657 Main av., Passaic
 Armstrong, Robt. R., 114 Pennington av., Passaic
 Ash, Frank W., 103 Carroll st., Paterson
 Atkinson, Jas. W., 485 S. Maple av., Glen Rock
 Atwood, Edw. A., 360 Park av., Paterson
 Barlow, Frank A., 91 Lafayette av., Passaic
 Barr, Joseph, 975 Madison av., Paterson
 Becker, G. L., 646 E. 28th st., Paterson
 Becker, Leo V., 69 Ward st., Paterson

PASSAIC COUNTY—Continued

- Bender, Theo. T., 666 Broadway, Paterson
 Bergin, J. V., 315 Broadway, Paterson
 Beshlian, Hagop K., 7 Lee pl., Paterson
 Bireley, M. F., 104 Avondale rd., Ridgewood
 Bohl, Louis J., 320 Broadway, Paterson
 Bongiorno, Henry D., 516 River st., Paterson
 Bonynge, Henry A., 123 Prospect st., Ridgewood
 Botbyl, B. W., 927 Madison av., Paterson
 Boylan, Lawrence B., 630 Main st., Paterson
 Brancato, Peter, 17 Church st., Paterson
 Brevoort, Henry M., Main st., Lodi
 Bromberg, Chas. B., 107 Lexington av., Passaic
 Brooks, S. S., 62 12th av., Paterson
 Butterfield, Arey A., Passaic Nat. Bk. Bldg., Pas'c
 Cantrell, W. C., 88 Union st., Clifton
 Carlisle, John H., 129 Prospect st., Passaic
 Carlough, D. J., 426 Ellison st., Paterson
 Catanzaro, F., 151 Jefferson st., Passaic
 Caverly, Fred S., 21 Grove st., Passaic
 Chase, W. E., 587 Main st., Passaic
 Chester, Saul W., 264 Graham av., Paterson
 Chrisman, Irving, 408 Ellison st., Paterson
 Ciccone, Anthony, 389 Grand st., Paterson
 Clay, Thomas A., 351 Totowa av., Paterson
 Cogan, Henry, 128 Carroll st., Paterson
 Cole, L. Frank, 242 Broadway, Paterson
 Colfax, Wm. S., 33 Bartholf av., Pompton Lakes
 Connolly, T. Vincent, 54 Hamilton st., Paterson
 Cortese, A. E., 119 Jasper st., Paterson
 Cremens, John F., 144 Carroll st., Paterson
 Crounse, D., 84 Broadway, Passaic
 Curtis, A. M., 445 Van Houten st., Paterson
 Dawson, Harry E., 618 24th st., Paterson
 Delario, A. J., 56 Cross st., Paterson
 De Mattia, Michael, 71 Cedar st., Paterson
 Denton, Peter P., 951 Madison av., Paterson
 De Rosa, Armond, 290 Union Blvd., Paterson
 De Rosa, John, 150 Fair st., Paterson
 De Yoe, Leon E., 602 Broadway, Paterson
 Dingman, N. M., 351 Van Houten st., Paterson
 Drake, Daniel E., Greenw'd Lake rd., Newf'nd'l'd
 Duncan, Owsley B., 602 E. 35th st., Paterson
 Dunning, Walter L., 533 River st., Paterson
 Durant, H. J., 526 Broadway, Paterson
 Dwyer, Henry E., 261 Madison av., Passaic
 Dwyer, William A., 99 Park av., Paterson
 Edekrant, Walter L., 82 President st., Passaic
 Elkings, Frank P., Paterson
 Feigenoff, Israel, 420 Broadway, Paterson
 Fisher, Samuel, 808 Madison av., Paterson
 Fliteroft, William, 510 River st., Paterson
 Gallo, James S., Haledon
 Giambra, S. M., 666 Broadway, Paterson
 Gillson, Hugh V., 21 Lee pl., Paterson
 Gillson, John T., 170 Broadway, Paterson
 Ginsberg, Samuel, 136 Broadway, Passaic
 Glasgow, Thomas, 120 Passaic av., Passaic
 Gochman, Henry M., 166 Hamilton av., Paterson
 Golding, Harry N., 180 Carroll st., Paterson
 Gordon, A., 616 Main av., Passaic
 Gordon, Clifford M., 52 Main st., Paterson
 Gordon, Osher, 119 Lexington av., Passaic
 Graham, A. F., 42 Park av., Paterson
 Graham, Theodore K., 278 Park av., Paterson
 Greengrass, Jacob J., 146 Broadway, Paterson
 Hagen, Orville R., 266 Van Houten st., Paterson
 Hall, W. W., 266 Van Houten st., Paterson
 Hambricht, A. M., Paterson
 Harreys, Chas. W., 714 Broadway, Paterson
 Hollingsworth, H. H., 86 1st st., Clifton
 Holmes, F. J. E., 151 Fair st., Paterson
 Holt, Herman Harold, 285 Graham av., Paterson
 Hughes, J. V., 657 Main av., Passaic
 Ives, Edward I., 24 Stevens av., Little Falls
 Irving, Albert, Albert Court, Radburn
 Jacob, William H., 99 N. Main av., Paterson
 Jahn, Albert, Pas. Nat'l Bank, Passaic
 Jani, Frank, 297 Lexington av., Passaic
 Jarmulowsky, Harry, 237 Broadway, Paterson
 Joelson, Morris S., 577 Broadway, Paterson
 Johnsen, S. W., 49 Passaic av., Passaic
 Joseph, Morris, 271 Lexington av., Passaic
 Kane, Charles J., 349 Grand st., Paterson
 Keating, C. A., 177 Ellison st., Paterson
 Keller, F. J., 795 Broadway, Paterson
 Keppler, Charles, Jr., 723 Allwood rd., Clifton
 Kim, Gay Bong, 528 Totowa rd., Totowa
 Kinney, Burton O., 41 Lincoln av., Little Falls
 Kleiner, Samuel, 162 Hamilton av., Paterson
 Koerber, George, 136 Prospect st., Passaic
 Kroll, Adolph, Jr., 103 Van Buren st., Passaic
 Laauwe, H. W., 198 Haledon av., Paterson
 Landaw, Louis, 583 Broadway, Paterson
 Lawrence, Elias D., Paterson
 Lemay, A. T., 30 Church st., Paterson
 Leonard, E. A., 771 Madison av., Paterson
 Levendusky, D. E., 52 Market st., Passaic
 Levine, D. B., 282 Broadway, Paterson
 Levine, Israel, 215 Broadway, Paterson
 Levine, Sidney C., 459 Park av. & 30th st., Pt's'n
 Levinsohn, S. A., 584 Broadway, Paterson
 Levy, Herman, 219 Lexington av., Passaic
 Linares, A. C., 208 Market st., Paterson
 Lipton, L., 67 Passaic av., Passaic
 Lobsenz, N., 294 Broadway, Paterson
 LoMauro, Jas. R., 73 Gron st., Passaic
 Low, Donald B., 529 Broadway, Paterson
 Lucas, Henry H., 266 Van Houten st., Paterson
 Lucent, S. Bell, 48 Main st., Little Falls
 MacAlister, Wm. W., 333 Van Houten st., Paters'n
 MacGregor, A., 379 Ellison st., Paterson
 MacQuffie, R. N., 657 Main av., Passaic
 MacMillan, Wright, 23 Passaic av., Passaic
 McBride, Andrew F., 30 Church st., Paterson
 McCamey, Kenneth E., 174 Carroll st., Paterson
 McCarthy, G. L., 496 Union av., Paterson
 McCoy, John C., 292 Broadway, Paterson
 McDede, Frank F., 922 Main st., Paterson
 McDonald, R. J., 294 Broadway, Paterson
 McPherson, M. E., 171 Diamond Bdg. av., Hawth'e
 Maclay, Joseph A., 181 E. 33rd st., Paterson
 Magennis, Bryan C., 170 Hamilton av., Paterson
 Mailer, Andrew Robert, 571 Park st., Montclair
 Maloney, L. F., 156 2nd st., Clifton
 Manley, Thos. E., 390 Park av., Paterson
 Maps, Howard L., 53 Passaic av., Passaic
 Marini, D., 40 Henry st., Passaic
 Markel, A., 320 Broadway, Paterson
 Markowitz, Louis, 16 Church st., Paterson
 Marsh, Elias J., 400 Van Houten st., Paterson
 Masucci, A., 34 Ward st., Paterson
 Matthews, L. M., 657 Main av., Passaic
 Meier, William U., Ringwood av., Haskell
 Meloney, Lester F., 156 2nd st., Clifton
 Mendelsohn, D. H., 576 Broadway, Paterson
 Meneve, A., 87 Bridge st., Paterson
 Meyers, F. R., 326 Park av., Paterson
 Michela, Luigi S., 206 Carroll st., Paterson
 Mills, Alvah V., Lindsley rd., Little Falls
 Mitchell, Charles R., 311 Broadway, Paterson
 Morrill, James P., 310 Broadway, Paterson
 Murn, Charles J., 48 Smith st., Paterson
 *Neer, Frank, Paterson
 Neer, William, 245 Broadway, Paterson

PASSAIC COUNTY—Continued

- Nesbit, Elizabeth, N. J. Tr'n'g School, Little Falls
 Nye, Howard H., 174 Broadway, Paterson
 O'Brien, D. M., 162 Lexington av., Passaic
 O'Brien, J. H., 204 Madison pl., Passaic
 Okin, I., 23 Passaic av., Passaic
 O'Lapnick, M. M., Paterson
 Oram, Joseph H., 495 Broadway, Paterson
 Palmer, Francis R., 27 Monroe st., Passaic
 Park, M. B., 360 Park av., Paterson
 Payawall, J. L., 170 Broadway, Paterson
 Pelusio, August N., 269 Carroll st., Paterson
 Perneti, A. M., 338 6th av., Paterson
 Phelps, J. E., 203 Park av., Paterson
 Piller, Jacob, 245 Broadway, Paterson
 Plinke, Fritz, 159 Lexington av., Passaic
 Polizzotti, J. L., 193 Park av., Paterson
 Polowe, David, 558 E. 27th st., Paterson
 Prince, Robert A., 272 Park av., Paterson
 Randazzo, Anton P., 82 Prospect st., Passaic
 Rauschenbach, Paul E., 223 Broadway, Paterson
 Reading, H. E., 538 E. 29th st., Paterson
 Reeves, E., 195 Lexington av., Passaic
 Reynolds, Earl C., 657 Main av., Passaic
 Reynolds, Harry C., 657 Main av., Passaic
 Roemer, Jacob, 213 Broadway, Paterson
 Roy, Jos. N., 95 17th av., Paterson
 Russell, Chas. B., 119 Hamilton av., Paterson
 Ryan, John N., 158 Lexington av., Passaic
 Salzman, Nathan, 714 Broadway, Paterson
 Sanfacon, Thomas A., 82 Ward st., Paterson
 Schultz, A. M., 379 Union av., Paterson
 Scielzo, M. F., 777 Madison av., Paterson
 Scribner, Charles H., Hamburg Tyke, Paterson
 Shapiro, L. G., 375 Broadway, Paterson
 Shapiro, David, Passaic
 Shulman, Abraham, 528 E. 29th st., Paterson
 Sieveke, J., 106 Lexington av., Passaic
 Simon, Morris L., 174 Washington pl., Passaic
 Slaff, F., 16 Grove st., Passaic
 Sloan, Samuel L., 182 Belmont av., Paterson
 Smith, E. W., 657 Main av., Passaic
 Smith, Leon A., 72 Grove st., Passaic
 Spickers, William, 6 Church st., Paterson
 Stark, M., 557 Broadway, Paterson
 Stein, Harry M., 227 W. Broadway, Paterson
 Steinberg, Benj. Louis, Four Corners, Singac
 Stinson, Richard, 641 E. 18th st., Paterson
 Stolz, R. R., 23 Passaic av., Passaic
 Sucoff, Moses C., 158 Hamilton av., Passaic
 Surnamer, Isaac, 345 Broadway, Paterson
 Sutherland, W. W., 320 Broadway, Paterson
 Taber, L., 266 Van Houten st., Paterson
 Tellman, D. H., 120 Lexington av., Passaic
 Temple, Arthur H., 164 Jefferson st., Passaic
 Terhune, Percy H., 171 Paulison av., Passaic
 Thorne, Wm. P., 30 Main st., Butler
 Todd, Francis H., 83 Auburn st., Paterson
 Tomkins, Wm., Hohokus
 Tuers, George E., 418 Park av., Paterson
 Tweddel, George K., 239 Broadway, Paterson
 Undinsky, Hyman J., 29 Passaic av., Passaic
 Vanderbeek, Andrew B., 174 Broadway, Paterson
 Vander Clock, C., 23 Passaic av., Passaic
 Van Erde, Alfred H., 339 Laf'y'te av., Hawth'rne
 Van Riper, A. Ward, 605 Main av., Passaic
 Van Schott, G. J., Jr., 245 Lexington av., Passaic
 Van Urk, Frederick T., 149 Lexington av., Passaic
 Van Winkle, John S., 297 Broadway, Paterson
 Vosburg, Fred, 125 Prospect st., Passaic
 Vreeland, Ralph J., 266 Van Houten st., Paterson
 Walker, Harold G., Everett av., Wyckoff
 Walton, Gordon G., 17 Church st., Paterson
 Warburton, Jack C., 71 Ward st., Paterson
 Warren, D. E., 265 Gregory av., Passaic
 Warren, Jacob, 372 E. 35th st., Paterson
 Wassing, Hans, 695 Broadway, Paterson
 Weinert, H. V., 162 Lexington av., Passaic
 Westerhoff, P. A., Highland av., Midland Park
 Widetsky, Alfred, 69 Hamilton av., Paterson
 Wilkinson, Boyd E., 266 Van Houten st., Paterson
 Willard, Harry S., 266 Van Houten st., Paterson
 Williams, Hiram, 230 Lexington av., Passaic
 Winters, Walter M., 288 Broadway, Paterson
 Wishnach, Meyer, 318 Broadway, Paterson
 Wolfe, A., Paterson
 Wolfson, H., 324 Broadway, Paterson
 Wry, Dean A., 244 Dayton av., Clifton
 Yager, Jacob A., 6 Church st., Paterson
 Yates, John S., 414 Ellison st., Paterson

Associate Members

Gallo, James F., 32 Zabriskie st., Haledon
 Scielzo, M. F., 777 Madison av., Paterson

Number of active members and basis of representation, 242, March 15, 1934.

100 per cent paid up March 15, 1934.

*Deceased.

SALEM COUNTY (17)

Society organized May 4, 1880. Meets second Wednesday in February, April, October and December. Social meeting in May. Annual meeting in October.

President

Hilliard, William T., Salem

Vice-President

Perry, Frank L., Woodstown

Secretary and Treasurer

Green, D. W., Salem

Reporter

James, William H., Pennsville

Censors

James, W. H., Pennsville
 Summerill, John M., Pennsgrove
 Perry, Frank L., Woodstown

Bramble, Halsey S., Elmer
 Davis, Richard M. A., Salem
 Dunn, John S., Salem
 Evans, E. E., Pennsgrove

Fleming, C. L., Pennsgrove
 Green, David W., Salem
 Hilliard, William T., Salem
 Hummel, L. C., Salem
 Hummel, L. H., Salem
 James, William H., Pennsville
 Mackes, C. L., Woodstown
 Miller, Louis H., Woodstown
 Perry, Frank L., Woodstown
 Prigger, E. R., Pennsgrove
 *Sherron, Clifford M., Salem
 Summerill, John M., Pennsgrove
 Sutter, Harry F., Pennsgrove

Number of active members and basis of representation, 16, March 15, 1934.

100 per cent paid up March 15, 1934.

*Deceased.

SOMERSET COUNTY (18)

Society organized May 21, 1816. Meets second Thursday afternoon in February, April, June, October and December.
Annual meeting in October.

President

McConaughy, Francis, Somerville.

Vice-President

Hegeman, R. F., Somerville

Secretary

Sferra, Alfred F. W., Bound Brook

Treasurer

Lawton, A. A., Somerville

Reporter

Young, James L., Somerville

Censors

Brittain, E. G., Bound Brook

Meigh, Josiah, Bernardsville

Flynn, T. H., Somerville

Adams, Rayford K., Skillman
Albrecht, W. J., Somerville
Allis, Jere A., 1210 Evergreen av., Plainfield
Anderson, John E., Neshanic
Barbour, Geo. E., Somerville
Beekman, John B., Bedminster
Borow, Benjamin, Bound Brook
Borow, Henry, Bound Brook
Borow, Lewis, Bound Brook
Borow, Maurice, Bound Brook
Brittain, Elmer G., Bound Brook
Cooley, R. L., Dunellen
Cooper, J. Howard, East Millstone
Craig, Henry August, Somerville
Crawford, John W., Bedminster
Dundon, A. H., North Plainfield
Earp, Ruth, Bernardsville
East, J. Cooper, Skillman
Ely, Lancelot, Somerville
Field, Frank L., Far Hills

Flint, Edgar T., Raritan
Flynn, Thomas A., Somerville
Francis, Adaline M., Somerville
Gray, W. B., North Plainfield
Greenberg, George A., Somerville
Halsted, Charles F., Somerville
Hegeman, Runkle F., Somerville
Hurd, Emerson F., Bound Brook
Husted, S. H., Neshanic
Kay, Clarence R., Peapack
Knight, Augustus S., Far Hills
Lawton, Anderson A., Somerville
Levy, A., Somerville
Long, William H., Somerville
McConaughy, Francis, Somerville
Massey, J. B., Somerville
Meigh, Josiah, Bernardsville
Pigott, Albert W., Skillman
Pogoloff, Samuel H., Manville
Renner, Dan Smith, Skillman
Robinson, John T., Bound Brook
Sferra, Alfred F. W., Bound Brook
Sherlock, Margaret E., Vinel'd State Sch'l, Vinel'd
Smalley, Mahlon C., Peapack
Stillwell, Aaron L., Somerville
Wallach, B., North Plainfield.
Wild, Frederick A., Bound Brook
Young, James L., Somerville
Zeglio, Peter J., North Plainfield

Honorary Members

All Medical Officials and Medical Staff of the
Veterans' Hospital in Millington.

Number of active members and basis of representation, 49, March 15, 1934.

100 per cent paid up March 15, 1934.

*Deceased.

SUSSEX COUNTY (19)

Society organized August 22, 1829. Meets bi-monthly, September to May, inclusive. Annual meeting second Tuesday in September.

President

Spencer, J. H., Newton

Vice-President

Johnson, George T., Branchville

Secretary

Wilbur, Frederick P., Franklin

Treasurer

Pooley, Thomas R., Jr., Newton

Reporter

Morrison, Frederick H., Newton

Censors

Coleman, Joseph G., Hamburg
Smith, Warren H., Newton
Voorhees, Lamar, Newton

Cole, Blase, Newton
Coleman, Joseph G., Hamburg
Drake, L. B., Ogdensburg
Jacob, Albert M., Sparta

Johnson, George, Branchville
Landis, Edwin W., Stillwater
McVeigh, Charles, Stanhope
Morrison, Frederick H., Newton
Pellett, T. L., Hamburg
Pooley, Thomas R., Jr., Newton
Roy, Bert W., Sussex
Scott, F., Franklin
Smith, Warren H., Newton
Spencer, J. H., Newton
Spurgeon, D. L., Newton
Taylor, Edward H., Franklin
Uptigrove, E. P., Vernon
Voorhees, Lamar, Newton
Wilbur, Frederick P., Franklin

Honorary Members

Cole, Martin H., Hainesville
Pellett, Jackson B., Hamburg

Number of active members and basis of representation, 19, March 15, 1934.

100 per cent paid up March 15, 1934.

UNION COUNTY (20)

Society organized June 7, 1869. Meets second Wednesday in January, April, July and October. Annual meeting in October.

President

Morris, Watson B., Millburn

Vice-President

Krans, Edward S., Plainfield

Secretary

Horre, George W. H., Elizabeth

Treasurer

Hoover, Alden R., Elizabeth

Reporter

Shirrefs, Russell A., Elizabeth

Censors

Schlichter, Charles H., Elizabeth

Currie, N. W., Plainfield

Prout, Thos. P., Summit

Reiner, Jacob, Elizabeth

Shangle, Milton, Elizabeth

Abel, Henri E., 345 Union av., Elizabeth
Ackerman, Arthur F., 129 Summit av., Summit
Ard, Frank C., 604 Park av., Plainfield
Armstrong, L. B., 121 S. Euclid av., Westfield
*Anthony, William H., 518 Park av., Plainfield
Arthur, Frances, 156 Chilton st., Elizabeth
Austin, T. R., 16 Alden st., Cranford
Babbitt, Hugh M., Jr., 503 Park av., Plainfield
Baker, Raymond Dewitt, 52 DeFor. av., Summit
Barr, A. H., 830 Wood av., Linden
Beisler, Lawrence G., 1528 N. Broad st., Hillside
Bensley, Maynard G., 129 Summit av., Summit
Berenson, Samuel J., 441 Elizabeth av., Elizabeth
Birrell, R. G., 554 Westminster av., Elizabeth
Blair, T. D., 414 Park av., Plainfield
Bloch, Harry, 200 E. Jersey st., Elizabeth
Blumberg, Jack, 504 Westminster av., Elizabeth
Blythe, Roland P., 30 Springfield av., Cranford
Boozan, Wm. E., 1139 E. Jersey st., Elizabeth
Bowles, Harry H., 36 Woodland av., Summit
Boyes, J. G., 1326 Chetwood av., Plainfield
Brock, H. F., 417 W. Broad st., Westfield
Brokaw, Chris. A., 1405 North av., Elizabeth
Brown, L. Greeley, 173 Madison av., Elizabeth
Brown, William H., 29 3rd st., Elizabeth
Bunting, P. DuBois, 712 N. Broad st., Elizabeth
Burnett, Thos. F., 151 Court st., Elizabeth
Burritt, Norman W., 30 Beachwood rd., Summit
Butenas, Jos. J., 300 1st av., Elizabeth
Byington, R., 261 Springfield av., Summit
Cantini, Raphael, 924 Plainfield av., Plainfield
Card, Charles F., 54 Elm av., Rahway
Carlin, Edward J., 20 Jacques av., Rahway
Carpenter, C. C., 129 Summit av., Summit
Carstarphan, Wm. T., 819 Park av., Plainfield
Casilli, A. R., 618 Newark av., Elizabeth
Chaiken, Louis H., 1024 E. Jersey st., Elizabeth
Chapman, O. P., 270 Morris av., Elizabeth
Childers, Robert J., 604 Park av., Plainfield
Cole, Walter H., 535 Westfield av., Elizabeth
Communale, A. R., 63 Irving st., Rahway
Corbusier, H. D., 612 Park av., Plainfield
Crabtree, Loren H., 142 Bellevue av., Elizabeth
Cregar, Peter B., 420 Grant av., Plainfield
Cronin, Francis J., 730 South st., Elizabeth
Currie, Norman W., 508 Central av., Plainfield
Daggett, E. Hugh, 441 W. Front st., Plainfield
Daron, Simeon, 405 Westminster av., Elizabeth
Davidson, E. Norwell, 102 Elm st., Linden

Davis, F. C., 14 Irving pl., Summit

Davis, Stanton H., 420 Park av., Plainfield

Day, Willis B., 154 E. 7th st., Plainfield

DeCesare, F. D., 500 Walnut st., Roselle

Decker, Charles T., 215 Prospect av., Westfield

DeFreitas, Clement, 423 W. 4th st., Plainfield

Dengler, H. P., Morris av., Springfield

Dennin, Jos. W., 308 Chestnut st., Roselle

Disbrow, G. Ward, 126 Mountain av., Summit

Drury, Alfred J., E 2d av., Roselle Park

duBusc, L. C. Victor, 399 Westfield av., Elizabeth

Durrah, Fred F., 310 Plainfield av., Plainfield

Eason, S. W., 48 DeForest av., Summit

Edgar, Malcolm S., 129 Summit av., Summit

Ferguson, Chas., 435 Westminster av., Elizabeth

Fiedler, M., 1012 E. Jersey st., Elizabeth

Fitch, Thomas, 744 Watchung av., Plainfield

Ford, Theodore R., 19 Prospect st., Summit

Fordyce, C. P., P. O. Box 322, Westfield

Foster, Frank L., 320 Springfield av., W. Cranf'd

Franklin, Jos. E., 127 Westfield av., Elizabeth

Friedburg, Geo. H., 1139 E. Broad st., Elizabeth

Frohwein, Ida H., 119 Morristown rd., Elizabeth

Funk, Joseph, 615 Elizabeth av., Elizabeth

Galloway, George E., 109 Milton av., Rahway

Geary, Paul, 923 Park av., Plainfield

Gelber, L., 2052 Morris av., Union

Gerendasy, J., 225 E. Jersey st., Elizabeth

Gibbs, Alice S., 339 Union av., Elizabeth

Gibson, Chas. F., 1 Summit av., Summit

Giglio, A. S., 626 Elizabeth av., Elizabeth

Gilpin, Friend B., 118 North av. W., Cranford

Gittelman, Morton, 1028 E. Jersey st., Elizabeth

Glaser, E., 218 Marshall st., Elizabeth

Glass, Benjamin E., 609 Watchung av., Plainfield

Glasston, H. M., 628 N. Wood av., Linden

Goldfield, Harold H., 225 E. Jersey st., Elizabeth

Goldmacher, H. B., 555 S. Broad st., Elizabeth

Goldstein, H. H., 1065 E. Jersey st., Elizabeth

Goodrich, S. L., St'd'd Oil Co. of N. J., Jer. City

Gorezyea, A. G., 538 S. Broad st., Elizabeth

Green, James S., 463 N. Broad st., Elizabeth

Gregory, R. A., 121 E. 7th st., Plainfield

Griesmier, Zador L., 1143 E. Jersey st., Elizabeth

Guidi, Guido M., 212 Christine st., Elizabeth

Hall, Winthrop H., 201 Tuttle Pkwy., Westfield

Hallock, W. J., Berkeley Height, Summit

Hanrahan, Jas. N., 678 N. Broad st., Elizabeth

Harrison, Joseph B., 302 E. Broad st., Westfield

Haseltine, S. L., 410 Westminster av., Elizabeth

Herrington, Lee, 147 Central av., Westfield

Hnat, Frederick, 450 Rahway av., Elizabeth

Hoffman, C. A., 729 Watchung av., Plainfield

Holland, Ruben J., Chancelor av., Linden

Holmes, Grace A., 1077 E. Jersey st., Elizabeth

Hoover, A. R., 5 Prince st., Elizabeth

Horre, Geo. W. H., 203 W. Jersey st., Elizabeth

Hubbard, Harry H. V., 121 E. 7th st., Plainfield

Hughes, Frederick J., 706 Park av., Plainfield

Hutton, F. T., 161 Crescent av., Plainfield

Imbleu, J. E. L., Stuyvesant av., Union

Johnson, Harold F., 915 Kensington av., Plainfield

Kapp, Carl G., 410 Westminster av., Elizabeth

Kemper, Harry T., 244 Monmouth rd., Elizabeth

Kieney, C. B., 137 Summit av., Summit

Kinch, F. A., 267 E. Broad st., Westfield

Knauer, George, 930 Elizabeth av., Elizabeth

Konzelman, Henry J., 50 King st., Hillside

*Korngut, Samuel, 306 First av., Elizabeth

Kralikauckas, Jos. K., 164 Park pl., Elizabeth

Krans, Clara DeH., 920 Park av., Plainfield

UNION COUNTY—Continued

- Krans, Edw. S., 920 Park av., Plainfield
 Kreutz, Paul J., 363 Union av., Elizabeth
 Kushner, Alexander, 48 Jacques av., Rahway
 Labow, Joseph J., 1063 E. Jersey st., Elizabeth
 Laird, George S., 127 Central av., Westfield
 Lance, E. W., 93 W. Milton av., Rahway
 Larrabee, C. H., 30 Beechwood rd., Summit
 Lathrop, Frederick W., 507 Park av., Plainfield
 Lawrence, Wm. H., Jr., 129 Summit av., Summit
 Leggett, L. H., 330 E. Broad st., Westfield
 Leggett, Thos. H., Jr., 706 Park av., Plainfield
 Lepree, Joseph A., 371 Morris av., Elizabeth
 Lerman, Irving, 1024 E. Jersey st., Elizabeth
 Lewis, Albert, 41 Retford av., Cranford
 Lieberman, David P., 1072 North av., Elizabeth
 Lieberman, Milton L., 1014 E. Grand st., Elizabeth
 Lilien, M. M., 162 Gruman av., Hillside
 Linke, Julian P., 245 E. Front st., Plainfield
 Livengood, Horace R., 587 Westminster av., Eliz.
 Lodal, George, 1141 E. Jersey st., Elizabeth
 Losada, Camella A., 19 Prospect st., Summit
 Lowell, M. E., Skillman
 Lufburrow, C. B., 411 W. Front st., Plainfield
 Lynch, Edward Thos., 748 Livingston rd., Eliz.
 Lyrly, J. M., 1116 Putman av., Plainfield
 Malatesta, C. S., 741 Kingston av., Plainfield
 Marone, C. R., 648 First av., Elizabeth
 McCallion, W. H., 722 Westminster av., Elizabeth
 McClintock, Elsie, 1435 Maple av., Hillside
 McElhinney, Dennis R., 110 W. Jer. st., Elizabeth
 McGinn, W. J., Front st., Scotch Plains
 *Mentzer, C. A., 42 Hollywood av., Hillside
 Miller, Robt. M., 382 Springfield av., Summit
 Moister, Roger W., 30 Beachwood rd., Summit
 Montfort, Robt. J., 1050 E. Jersey st., Elizabeth
 Moress, Edward J., 1501 Maple av., Hillside
 Morris, Thos. M., 503 Park av., Plainfield
 Morris, Watson B., 107 Morris av., Springfield
 Mravlag, Victor, 1064 E. Jersey st., Elizabeth
 Munger, Ray T., 727 Watchung av., Plainfield
 Murphy, Herschel S., 130 Grant av., E. R's'le P'k.
 Murray, Norman L., 129 Summit av., Summit
 Newman, Louis G., 316 E. Broad st., Westfield
 Nittoli, R. N., 660 E. Jersey st., Elizabeth
 Novello, Joseph A., 624 4th st., Elizabeth
 Obester, G. E., 801 E. Jersey st., Elizabeth
 O'Brien, D. J., 197 Spring st., Portland, Me.
 Orton, George Lee, 98 Elm st., Rahway
 *Perkins, J. L., 16 Alden st., Cranford
 Peters, Richard C., 923 Park av., Plainfield
 Phelan, W. F., 124 Chilton st., Elizabeth
 Prout, Thos. P., 19 Prospect st., Summit
 Quinn, Stephen T., 1143 E. Jersey st., Elizabeth
 Radding, M. B., 321 Elmora av., Elizabeth
 Randolph, John M., 131 Main st., Rahway
 Rathbone, T. H., 129 Summit av., Summit
 Reich, Jerome J., 1420 Maple av., Hillside
 Reiner, Jacob, 811 N. Broad st., Elizabeth
 Ripps, Maurice L., 331 Elmora av., Elizabeth
 Robertson, Grace M., 650 W. 7th st., Plainfield
 *Robinson, Moe, 1014 E. Grand st., Elizabeth
 Runkell, J. E., Scotch Plains
 Sadoff, Joseph, 116 Elmora av., Elizabeth
 Salvati, Leo H., 224 Walnut st., Westfield
 Schenk, Jos. R., 1173 Park av., Plainfield
 Schlichter, Chas. H., 556 N. Broad st., Elizabeth
 Schwartz, Samuel H., 414 Park av., Plainfield
 Schweitzer, Roman G., 860 E. Jersey st., Elizabeth
 Sell, Frederick W., 113 Commerce st., Rahway
 Seybold, Arthur D., 302 E. 7th st., Plainfield
 Seymour, Geo. A., 253 Orchard st., Elizabeth
 Shangle, Milt A., 34 Prince st., Elizabeth
 Sherman, Samuel H., 81 Elmore av., Elizabeth
 Shirrefs, Russell A., 55 Broad st., Elizabeth
 Sly, John L., 382 Springfield av., Summit
 Stanton, Nath. B., 734 Park av., Plainfield
 Staub, E. Milton, 531 E. Broad st., Westfield
 Steele, Stephen, 500 Wood av., Linden
 Stein, Emil, 607 Park av., Elizabeth
 Stein, George H., 411 Westminster av., Elizabeth
 Stein, Isadore, 210 Elizabeth av., Elizabeth
 Stein, Martin H., 163 Second st., Elizabeth
 Stephenson, G. A., Jersey City Hosp., Jersey City
 Stern, Arthur, 224 E. Jersey st., Elizabeth
 Steuart, David T., 10 De Barry pl., Summit
 Strelinger, Edw. A., 4800 Walnut st., Philadelphia
 Strickland, G. W., 123 First av., Roselle
 Strom, A., 410 W. 7th st., Plainfield
 Stuart, J. Earle, 552 E. Second st., Plainfield
 Thomas, Mary L., Village for Epileptics, Skillman
 Tidaback, John D., 447 Springfield av., Summit
 Turner, Wm. F., 519 Magie st., Elizabeth
 Vail, Jas. Lindley, 28 Holly st., Cranford
 Van Horn, Alfred F., 514 Central av., Plainfield
 Vinciguerra, Michael, 410 Westminster av., Eliz
 Vitale, Dominic V., 681 Newark av., Elizabeth
 Vogel, H. Austin, 1060 E. Jersey st., Elizabeth
 Wacker, William F., 42 Hollywood av., Hillside
 Wade, Simeon F., 555 Newark av., Elizabeth
 Wagner, Otto, 111 Stiles av., Elizabeth
 Walsh, Ronald J., 323 Chestnut st., Roselle
 Walsh, Thomas J., 335 S. Broad st., Elizabeth
 Ward, Leo J., 137 W. Jersey st., Elizabeth
 Warncke, F. H., 523 Westfield av., Elizabeth
 Wegryn, Louis S., 254 First av., Elizabeth
 Weigel, Edgar Wm., 970 Park av., Elizabeth
 Weigel, Elmer P., 727 Watchung av., Plainfield
 Williams, Frank A., 324 W. Jersey st., Elizabeth
 Williams, L. D., 518 Park av., Plainfield
 Woody, McIver, 458 Union av., Elizabeth
 Yood, Raphael, 401 Grant av., Plainfield
 Young, Franklin C., 120 Summit av., Summit
 Zeitlin, H. H., 943 N. Wood st., Linden

Transfers

Durin, Simeon, received from Middlesex Co.
 Radding, Morris B., received from New York
 Vitale, Dominic, received from Hudson Co.

Number of active members and basis of representation, 229.

100 per cent paid up March 15, 1934.

*Deceased.

WARREN COUNTY (21)

Society organized February 15, 1826. Meets third Tuesday in January, April, July and October. Annual meeting in October.

President

Krauss, Emory, Phillipsburg

Vice-President

Baldauf, Herman, Belvidere

Secretary

Hackett, L. W., Washington

Treasurer

Cummins, G. Wyckoff, Belvidere

Reporter

*Smith, Chas. B., Washington

Censors

Bossard, H. B., Phillipsburg

Lyon, C. H., Phillipsburg

Albertson, W. C., Belvidere

Allen, William C., Blairstown

Baldauf, Herman, Belvidere

Bloom, Lawrence H., 8 Market st., Phillipsburg

Bossard, Henry B., Phillipsburg

Brasefield, Edgar N., Phillipsburg

Cummins, G. Wyckoff, Belvidere

Curtis, Frank W., Stewartsville

Drake, Paul F., Phillipsburg

Gordon, William, Blairstown

Hoagland, Louis B., Oxford

Krauss, Emory, Phillipsburg

La Riew, Fred J., Washington

Lyon, C. H., Phillipsburg

*McKinstry, Frank P., Washington

Pursell, William Dana, Phillipsburg

Shimer, Floyd A., Phillipsburg

Skinner, William F., Washington

*Smith, Charles B., Washington

Spillane, T. H., Phillipsburg

Tunison, G. O., Oxford

Vail, Wm. Penn, Blairstown

Varney, W. H., Washington

West, G. F., Phillipsburg

Wing, Raymond, Blairstown

Zuck, A. C., Washington

Number of active members and basis of representation, 24, March 15, 1934.

100 per cent paid up March 15, 1934.

*Deceased.

SUMMARY

Total Active Membership	Counties reporting many active members as were listed in the Official List last year are carried in this column as being 100 per cent paid up.	Counties showing an actual gain in membership including active and associate members.	New Members
ATLANTIC 107			ATLANTIC 5
BERGEN..... 160			BERGEN 12
BURLINGTON ... 53			BURLINGTON 2
CAPE MAY 20			CAPE MAY 2
CAMDEN 150		BURLINGTON	CAMDEN 15
CUMBERLAND .. 51		CAMDEN	CUMBERLAND 4
ESSEX 735	BURLINGTON	CUMBERLAND	ESSEX 64
GLOUCESTER 36	CAMDEN	GLOUCESTER	GLOUCESTER 3
HUDSON 391	CUMBERLAND	GLOUCESTER	HUDSON 27
HUNTERDON 20	ESSEX	ESSEX	HUNTERDON 2
MERCER 169	GLOUCESTER	HUDSON	MERCER 18
MIDDLESEX 112	MERCER	MERCER	MIDDLESEX 4
MONMOUTH 91	MONMOUTH	MONMOUTH	MONMOUTH 5
MORRIS 66	PASSAIC	PASSAIC	MORRIS 8
OCEAN 19	SALEM	SALEM	OCEAN 1
PASSAIC 242	SOMERSET	SOMERSET	PASSAIC 9
SALEM 16	SUSSEX	SUSSEX	SALEM 1
SOMERSET 49	UNION	UNION	SOMERSET 4
SUSSEX 19	WARREN	WARREN	SUSSEX 1
UNION 229			UNION 25
WARREN 24			WARREN 1
			<hr/> 213

Number of deaths during the year, 48.

Number of Associate Members in all the Component Societies, 109.

Number on the Official List, Feb. 5, 1933 2750

Number on Official List March 15, 1934 2757

New members elected in 1932-1933 135

New members elected in 1933-1934 213

J. B. MORRISON,
Secretary.

An Alphabetical List of the Members of the Medical Society of New Jersey

Compiled May, 1934

The figures in parenthesis refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

*Deceased.

- Abel, Elvira, Morristown (14)
 Abel, Henri E., 345 Union av., Elizabeth (20)
 Abey, W. J. H., 23 N. Del. av., Pennington (11)
 Abrams, A. B., 668 Clinton av., Newark (7)
 Ackerman, Arthur F., 129 Summit av., Summit (20)
 Ackerman, Edward, Dover (14)
 Ackerman, James F., 1010 Grand av., Asb. Pk (13)
 Ackerman, Joseph, 404 Asbury av., Asbury Pk (13)
 Ackley, D. B., 21 N. Clinton av., Trenton (11)
 Adams, Charles F., 34 W. State st., Trenton (11)
 Adams, Flora, Hackensack (2)
 Adams, John K., 3 Prospect st., East Orange (7)
 Adams, Rayford K., Skillman (18)
 Adams, Samuel, 29 Highland av., Jersey City (9)
 Adelman, Benj. B., 190 Clinton av., Newark (7)
 Adler, Joseph, 933 Ave. C, Bayonne (9)
 Africano, J. V., 4246 Hudson Blvd., Union City (9)
 Ainley, H. Bryson, 246 Union st., Jersey City (9)
 Albano, Joseph, 535 N. 7th st., Newark (7)
 Albee, Geo. C., 219 S. Orange av., S. Orange (7)
 Albertson, W. C., Belvidere (21)
 Albrecht, W. J., Somerville (18)
 Albright, Louis F., 210 Madison av., Sp'g Lake (13)
 Alexander, Hugo, 1029 Garden st., Hoboken (9)
 Alexander, Samuel, Park Ridge (2)
 Alexander, W. G., 48 Webster pl., Orange (7)
 Allan, James S., 49 Prospect st., E. Orange (7)
 Allen, G. Herbert, 181 Roseville av., Newark (7)
 Allen, I. L., 521 Palisade av., Union City (9)
 Allen, J. M., 657 Main av., Passaic (16)
 Allen, William C., Blairstown (21)
 Alling, Frederick A., 15 Washington st., Newark (7)
 Allis, Jere A., 1210 Evergreen av., Plainfield (18)
 Allman, David B., 104 St. Charles pl., Atl. City (1)
 Alpert, Edward, 661 Jersey av., Jersey City (9)
 Alter, Nicholas M., 410 Fairmount av., Jer. City (9)
 Altschul, Frank J., 177 Garfield av., L. Branch (13)
 Anderson, J. F., 195 College av., N. Brunswick (12)
 Anderson, John E., Neshanic (18)
 Anderson, Richard D., Burlington (3)
 Anderson, R. M., Hackensack (2)
 Anderson, William, 20 Kings H'w'y., Haddonfield (4)
 Andrae, Paul, 52 Werner av., Jersey City (9)
 Andrews, Clarence L., 1616 Pacific av., Atl. C'y (1)
 Andrus, David L., 805 Cooper st., Camden (4)
 Angelillo, Marc C., 333 Clifton av., Newark (7)
 Angell, Emmett D., 4 Sloan st., West Orange (7)
 Angelo, Jos. A., 1190 P't's'n Plank rd., Secaucus (9)
 *Anthony, William H., 518 Park av., Plainfield (20)
 Antonius, N. A., 27 W. Market st., Newark (7)
 Ambrose, Anthony, 71 Congress st., Newark (7)
 Applegate, E. T. R., 1125 Gr'nw'd av., Trenton (11)
 Applegate, G. T., 71 Livingston av., N. Br'sw'k (12)
 Applestein, Robert, 569 E. State st., Trenton (11)
 Appleton, Ralph, Farmingdale (13)
 Appold, Geo. D., Bergenfield (2)
 Ard, Frank C., 604 Park av., Plainfield (20)
 Areson, Wm. H., 152 Bellevue av., U. Montclair (7)
 Arla, Michael, 497 Mercer st., Jersey City (9)
 Arlitz, Wm. J., 107 Newark st., Hoboken (9)
 Armstrong, L. B., 121 S. Euclid av., Westfield (20)
 Armstrong, R. R., 114 Pen'gton av., Passaic (16)
 Aronis, H. R., 239 E. Hanover st., Trenton (11)
 Arthur, Frances, 156 Chilton st., Elizabeth (20)
 Ash, Arthur F., 710 Blvd. East, Weehawken (9)
 Ash, Frank W., 108 Carroll st., Paterson (16)
 Ashcraft, Samuel F., Mullica Hill (8)
 Asher, Maurice, 186 Clinton av., Newark (7)
 Ashley, H. H., 192 W. State st., Trenton (11)
 Aszody, Paul, 340 Waverly av., Newark (7)
 Atkinson, A. W., 423 E. State st., Trenton (11)
 Atkinson, Jas. W., 485 S. Maple av., Glen Rock (16)
 Atwood, Edw. A., 360 Park av., Paterson (16)
 Auricmma, Michael, 419 Adams st., Hoboken (9)
 Austin, T. R., 16 Alden st., Cranford (20)
 Avery, Phillip S., Mid. Gen. Hosp., New Br'sw'k (12)
 Avidan, Maurice S., 30 Stratford pl., Newark (7)
 Axford, W. Homer, Chester (9)
 Axilrod, M. H., 2620 Pacific av., Atlantic City (1)
- ASSOCIATE MEMBERS
- Agnew, Hobart M., 27 S. Fullerton av., Montc'r (7)
 Ajamian, Harry M., 509 36th st., Union City (9)
 Alford, Ralph I., 9 N. Mountain av., Montclair (7)
 Allen, Raymond N., 114 Park st., Orange (7)
 Amdur, Louis A., 334 Westside av., Jersey City (9)
 Applebaum, I. L., 304 Fairmount av., Newark (7)
 Aranowitz, H. T., 11 E. 42nd st., Bayonne (9)
 Aronowitz, Harry, 68 Weequahic av., Newark (7)
 Babbitt, Hugh M., Jr., 503 Park av., Plainfield (20)
 Bachmann, Wm., 87 Hillcrest ter., E. Orange (7)
 Bacon, Mary, Bridgeton (6)
 Baechler, Jules, 439 16th st., W. New York (9)
 Baeseman, R. W., 501 Grant av., Asbury Park (13)
 Bagg, Linus W., 31 Lincoln Park, Newark (7)
 Bahnson, Conrad M., 170 Bowers st., Jer. City (9)
 Bailey, Wilson G., 512 Broadway, Camden (4)
 Bailyn, Emanuel, 331 16th st., W. New York (9)
 Baird, T. M., 124 Grand pl., Arlington (7)
 Baker, Augustus L., 389 Blackwell av., Dover (14)
 Baker, Banks S., 3021 Mt. Ephraim av., Camden (4)
 Baker, Charles F., 198 Clinton av., Newark (7)
 Baker, Elsworth F., State Hosp., Marlboro (13)
 Baker, Hugh H., Vineland (6)
 Baker, Maclyn, 638 Stuyvesant av., Irvington (7)
 Baker, Maurice E., 1149 Kaighn av., Camden (4)
 Baker, Philip W., High Bridge (10)
 Baker, Raymond Dewitt, 52 DeFor. av., Summlt (20)
 Baketel, S. H., Jersey City (2)
 Baldauf, Herman, Belvidere (21)
 Baldwin, Samuel H., 626 Clinton av., Newark (7)
 Balson, Z. D. E., 884 S. 14th st., Newark (7)
 Balze, H. R., Leonia (2)
 Banach, Leon, 2747 Boulevard, Jersey City (9)
 Banks, Winifred D., 6 N. Munn av., E. Orange (7)
 Barb, K. B., Kaighn & Princess avs., Camden (4)
 Barbarito, Wm. N., 135 Bentley av., Jersey City (9)
 Barbash, Samuel, 1902 Pacific av., Atlantic City (1)
 *Barber, Isaac, Phillipsburg (21)
 Barbour, Geo. E., Somerville (18)
 Barshaw, S. B., 5 Bentley av., Jersey City (9)

- Barkhorn, Chas. W., 223 Roseville av., Newark (7)
 Barkhorn, Henry C., 45 Johnson av., Newark (7)
 Barlow, Frank A., 91 Lafayette av., Passaic (16)
 Barnes, William J., Englewood (2)
 Barnshaw, Harold M., 2626 Federal st., Camden (4)
 Barr, A. H., 830 Wood av., Linden (20)
 Barr, Joseph, 975 Madison av., Paterson (16)
 Barrett, A. F., 835 Montgomery st., Jersey City (9)
 Barrett, Jos. F., 230 Parker st., Maplewood (7)
 Barrett, Wesley J., 517 Cooper st., Camden (4)
 Barrows, A. M., 440 Hamilton av., Trenton (11)
 Barrows, Victor, Pitman (8)
 Barry, R. G., 807 W. State st., Trenton (11)
 Bartlett, Clara K., 4301 Atl. av., Atlantic City (1)
 Basset, Lavern C., 320 N'wm'rket rd., Dunellen (12)
 Bassett, N. L., 109 States av., Atlantic City (1)
 Bauer, Harry W., Palmyra (3)
 Baum, Felix, 31 Lincoln Park, Newark (7)
 Baum, Samuel, 10 Osborne ter., Newark (7)
 *Bauman, John J., 2672 Boulevard, Jersey City (9)
 Beairsto, E. B., 178 W. State st., Trenton (11)
 Beaver, Jennie Dean, 8 Oliphant Pk., Morrist'n (14)
 Becker, G. L., 646 E. 28th st., Paterson (16)
 Becker, Fred C., 620 Benson st., Camden (4)
 Becker, Fred W., 14 Clinton pl., Newark (7)
 Becker, Sidney, Keyport (13)
 Becker, Leo V., 69 Ward st., Paterson (16)
 Becket, Geo. C., 350 Springdale av., E. Orange (7)
 Beekman, Jesse H., Sayreville (12)
 Beekman, John B., Bedminster (18)
 Behrens, Herman, 312 Webster av., Jersey City (9)
 Beideman, Casper M., 5 W. Maple av., M'ch'tv. (4)
 Beir, I. R., Haverford Apts., Atlantic City (1)
 Beisler, Lawrence G., 1528 N. Broad st., Hillside (20)
 Belford, R. J., 1st Nat. Bank Bldg., Princeton (11)
 Beling, Chris. C., 109 Clinton av., Newark (7)
 Bell, J. Finley, Englewood (2)
 Bell, Thomas, 340 Belmont av., Newark (7)
 Bellak, Ellis R., Leesburg (6)
 Bellis, Horace D., 437 E. State st., Trenton (11)
 Belting, Arthur W., P. O. Box 1215, Trenton (11)
 Ben-Asher, Solomon, 260 Bergen av., Jer'y City (9)
 Bender, Theo. T., 666 Broadway, Paterson (16)
 Benedict, A. C., 121 Irvington av., S. Orange (7)
 Bengelsdorf, A., 29 Clinton pl., Newark (7)
 Benjamin, Harold C., 59 Crescent av., Jer'y City (9)
 Bennett, Samuel D., Millville (6)
 Bennett, W. F., Essex Co. Sanatorium, Verona (7)
 Bensley, Maynard G., 129 Summit av., Summit (20)
 Bentley, David F., Jr., 406 Cooper st., Camden (4)
 Beradinelli, C. G., 92 8th av., Newark (7)
 Berenson, Samuel J., 441 Eliz. av., Elizabeth (20)
 Berg, S., 530 Central av., Newark (7)
 *Bergen, E. R., Princeton (11)
 Berger, Harry, 921 Clinton av., Trenton (11)
 Berger, W. A., 268 N. 7th st., Newark (7)
 Bergin, J. V., 315 Broadway, Paterson (16)
 Bergman, M. W., 825 S. 10th st., Newark (7)
 Berke, R. N., Hackensack (2)
 Berkow, Samuel G., 138 Market st., P. Amboy (12)
 Berlin, Joseph I., 9 Gifford av., Jersey City (9)
 Berman, H. Robert, 286 Roseville av., Newark (7)
 Berman, Jacob J., 409 Market st., Trenton (11)
 Beshlian, Hagop K., 7 Lee pl., Paterson (16)
 Beyer, Othmar J., 42 Laurel av., Irvington (7)
 Beyer, Wm., Jr., Englewood (2)
 Bianchi, Angelo R., 104 7th av., Newark (7)
 Bien, Frank A., 999 Clinton av., Newark (7)
 Bigelow, N. S., 117 Irvington av., S. Orange (7)
 Binder, Joseph, 422 Bergen av., Jersey City (9)
 Binder, Joseph, 149 Garfield av., Long Branch (13)
 Bingham, A. W., 144 Harrison st., East Orange (7)
 Bird, Frank L., Netcong (14)
 Birdsall, Clarence, 3 Small pl., Caldwell (7)
 Birelev, M. Franklin, 104 Avondale rd., R'ew'd (16)
 Birrell, R. G., 554 Westminster av., Elizabeth (20)
 Bissett, John V., 29 Hawthorne av., E. Orange (7)
 Bitten, Robert M., 33 Romaine av., Jersey City (9)
 Black, Alan B., Clarksboro (8)
 Black, L. W., Rutherford (2)
 Blackburne, George, 490 Central av., Newark (7)
 Blackwell, Enoch, Trenton Trust Bldg., Trenton (11)
 Blair, T. D., 414 Park av., Plainfield (20)
 Blaisdell, C. Byron, 48 Norwood av., L. Branch (13)
 Blakey, A. P., 475 Jersey av., Jersey City (9)
 Blampin, Winifred A., Galen Hall, Atlantic City (1)
 Blanchard, Kenneth, 25 S. Munn av., E. Orange (7)
 *Blanchard, O. R., 37 Clinton av., Jersey City (9)
 Blaugrund, Samuel, 190 W. State st., Trenton (11)
 Blauvelt, Grace B., Ridgewood (2)
 Bleick, Theodore E., 61 Van Ness pl., Newark (7)
 Bleick, Wm. D., 583 Prospect av., Maplewood (7)
 Bieier, Louis, 88 Clinton av., Newark (7)
 Blenkle, V. A., Teaneck (2)
 Bloch, Harry, 200 E. Jersey st., Elizabeth (20)
 Block, Marcus T., 177 Bloomfield av., Newark (7)
 Bloom, Lawrence H., 8 Market st., Phillipsb'g (21)
 Blum, Jos. M., 128 Mill st., Trenton (11)
 Blumberg, Jack, 504 Westminster av., Elizabeth (20)
 Blythe, Roland P., 30 Springfield av., Cranford (20)
 Bohl, Louis J., 320 Broadway, Paterson (16)
 Bongiorno, Henry D., 516 River st., Paterson (16)
 Bono, J., Northvale (2)
 Bonomo, M. J., 447 Springfield av., Newark (7)
 Bonyng, Henry A., 123 Prospect st., Ridgew'd (16)
 Bookrajian, Edw. N., 5436 Huds'n Blvd., N. B'rg'n (9)
 Bookstaver, B. P., Teaneck (2)
 Booth, William K., Boonton (14)
 Boothby, I. R., Glen Gardner (10)
 Boozan, W. E., 1139 E. Jersey st., Elizabeth (20)
 Borow, Benjamin, Bound Brook (18)
 Borow, Louis, Bound Brook (18)
 Borow, Maurice, Bound Brook (18)
 Borrow, Maurice, Bound Brook (18)
 Borshaw, Hyman, 108 Bentley av., Jersey City (9)
 Bortone, Frank, 2765 Boulevard, Jersey City (9)
 Boselli, Emile H., 614 15th st., Union City (9)
 Bossard, Henry B., Phillipsburg (21)
 Bostwick, Delazon S., Bridgeton (6)
 Bostwick, Wallace R., 56 Church st., Montclair (7)
 Botbyl, B. W., 927 Madison av., Paterson (16)
 Botti, John A., 236 Summit av., Jersey City (9)
 Boulden, George P., P. O. Box 5, Dunellen (12)
 Bowen, Horace, 2787 Boulevard, Jersey City (9)
 Bowles, Harry H., 36 Woodland av., Summit (20)
 Bowman, A. K., 272 Nassau st., Princeton (11)
 Bowyer, Frank F., 50 Gifford av., Jersey City (9)
 Boyd, John, East Front st., Red Bank (13)
 Boyes, J. G., 1326 Chetwood av., Plainfield (20)
 Boylan, Lawrence B., 630 Main st., Paterson (16)
 Boysen, Theo. H., 100 Phila. av., Egg Harbor (1)
 Brackett, Eliz. R., 349 Franklin av., Nutley (7)
 Bradford, Stella S., 16 Seymour av., Montclair (7)
 Bradley, Robt. A., 1616 Pacific av., Atlantic City (1)
 Bradshaw, John H., 27 High st., Orange (7)
 Brady, Thomas S., 678 Ave. C., Bayonne (9)
 Brake'ey, Elizabeth, 21 Trinity pl., Montclair (7)
 Bramble, Halsey S., Elmer (17)
 Brancato, Peter, 17 Church st., Paterson (16)
 Branch, W. Harold, 190 Duncan av., Jersey City (9)
 Brandenburg, L. W., 4620 Boulevard, Union City (9)
 Branin, Howard, Millville (6)
 Brasefield, Edgar N., Phillipsburg (21)
 Brauer, Selig, 234 Bergen av., Jersey City (9)
 Braun, Gus A., 391 Bergen st., Newark (7)
 Braunstein, S. C., 424 13th st., W. New York (9)
 Braunstein, Wm. P., 831 Blvd. East Weeh'ken (9)
 Bregman, Alexander, Edgewater (2)
 Breitstadt, C. A., 168 Delavan av., Newark (7)
 Brennan, A. T. V., Tenafly (2)
 Brennan Chas. L. S., 14 S. B'way, Gloucester (4)
 Brennan, John P., 306 Cooper st., Camden (4)
 Brennoch, Thos. McG., 3 Webster av., Jer. City (9)
 Breslow, S., 111 Market st., Perth Amboy (12)

Brevoort, Henry M., Main st., Lodi (16)
 Brewer, David R., 536 Market st., Gloucester (4)
 Brewer, William, Woodbury (8)
 Brick, G. J., 43 Cottage st., Jersey City (9)
 Brien, William M., 419 Main st., Orange (7)
 Briggs, H., 16 Undercliffe ter., West Orange (7)
 Brin, Anne J. S., 83 Lincoln Park, Newark (7)
 Brittain, Ehmer G., Bound Brook (18)
 Broadnax, Mary E., 83 Lincoln Park, Newark (7)
 Brodtkin, Eva T., 365 Osborne ter., Newark (7)
 Broukin, H. A., 365 Osborne ter., Newark (7)
 Brozdowski, J. J., 554 $\frac{1}{2}$ Jer. av., Jersey City (9)
 Brock, H. F., 417 W. Broad st., Westfield (20)
 Brody, M. J., 84 Bayard st., New Brunswick (12)
 Broesser, H. V., 105 Newark av., Hoboken (9)
 Brokaw, Chris. A., 1405 North av., Elizabeth (20)
 Bronberg, Chas. B., 107 Lexington av., Passaic (16)
 Brooks, S. S., 62 12th av., Paterson (16)
 Brooke, William W., 915 Ave. C, Bayonne (9)
 Brophy, Francis X., 2511 Boulevard, Jer. City (9)
 Brothers, J. H., 1172 Raymond blvd., Newark (7)
 Brozman, Morton M., 90 Avon av., Newark (7)
 Brouwer, Frank, Toms River (15)
 Brown, Chester R., 22 Midland av., Arlington (7)
 Brown, Conisile J., 101 S. 1st av., Atlantic City (1)
 Brown, C. T., Prudential Ins. Co., Newark (7)
 Brown, E. V., 585 Kearny av., Arlington (7)
 Brown, F. L., 67 Livingston av., N. Brunswick (12)
 Brown, Harvey S., 5 Club place, Freehold (13)
 Brown, J. L., Grantwood (2)
 Brown, Kenneth, 603 Asbury av., Asbury Park (13)
 Brown, Lewis W., 15 Fulton st., Newark (7)
 Brown, L. Greeley, 173 Madison av., Elizabeth (20)
 Brown, Richard J., 105 Ridgewood rd., S. Orange (7)
 Brown, Stanley, Glen av., Laurel Springs (4)
 Brown, William H., 29 Third st., Elizabeth (20)
 Brownin, W. Kempton, 120 Cen. st., M'h'ntv'le (4)
 Browning, Wm. J., 134 N. Centre st., M'rch'ntv'le (4)
 Bruder, A. J., 344 Fairmont av., Jersey City (9)
 Buckley, J. L., 684 Franklin av., Nutley (7)
 Buckley, R. T., Peddie School, Hightstown (11)
 Buermann, Robert, Lakewood (15)
 *Buermann, William, 9 Lincoln Park, Newark (7)
 Bull, Louis M., 92 Heller Prkwy., Newark (7)
 Bull, R. I., 531 W. Market st., Newark (7)
 Bull, W. J., 98 Park st., Montclair (7)
 Bulwinkle, Fred., Ocean blvd., Atlantic High'lds (13)
 Bumsted, Clarence, 235 Grafton av., Newark (7)
 Bunnell, Frederick N., Barnegat (15)
 Bunting, P. DuB., 712 N. Broad st., Elizabeth (20)
 Burbank, H. E., Lyndhurst (2)
 Burke, Stephen E., 212 First av., Newark (7)
 Burkett, William, Pitman (8)
 Burne, John J., 17 Gould av., Newark (7)
 Burnett, Chas. B., Main st., South River (12)
 Burnett, Thos. F., 151 Court st., Elizabeth (20)
 Burnham, L., Englewood (2)
 Burns, Edward L., 269 Broad st., Newark (7)
 Burns, G. C. H., Tenafly (2)
 Burbeau, Wm. P., 144 Harrison st., E. Orange (7)
 Burritt, Norman W., 30 Beachw'd rd., Summit (20)
 Burroughs, Edm. W., 701 W. State st., Trenton (11)
 Busansky, Samuel T., New Lisbon (3)
 Bush, Archer C., 40 Union av., Montclair (7)
 Busch, Herman, 38 Johnson av., Newark (7)
 Bush, Ralph K., 131 E. Park av., Merchantville (4)
 Busico, P. S., Englewood (2)
 Butcher, Charles, Heislerville (6)
 Butenas, Jos. J., 300 1st av., Elizabeth (20)
 Butler, Eustice C., 249 Bloomfield av., Caldwell (7)
 Butler, Vincent P., 921 Bergen av., Jersey City (9)
 Butterfield, A. A., P'sc Nat'l Bk. Bldg., Passaic (16)
 Buvinger, Chas. W., 50 Wash'g'n st., E. Orange (7)
 Buzby, B. Franklin, 414 Cooper st., Camden (4)
 Byers, C. W., Rutherford (2)
 Ryington, R., 261 Springfield av., Summit (20)

ASSOCIATE MEMBERS

Barone, Francis A., 175 Fulton st., Jersey City (9)
 Bergen, Marshall, 273 Bergen av., Jersey City (9)
 Being, C. Abbott, 111 Clinton av., Newark (7)
 Blinn, Arthur R., Homeop. Hosp., E. Orange (7)
 Burton-Ouitz, R., Palisade (2)
 Cacciarelli, Robt. A., 517 Roseville av., Newark (7)
 Cahill, L. A., 353 Lafayette st., Newark (7)
 Caldwell, J. A., 45 S. Mountain av., Montclair (7)
 Callery, Wm., 4 Columbia ter., Weehawken (9)
 Calvert, Wm. C., 220 Central av., Orange (7)
 Calvin, Charles, 80 Commerce st., Perth Amboy (12)
 Camche, L. J., 250 Renner av., Newark (7)
 Cameron, Ed. A., 186 S. Burnett st., E. Orange (7)
 Campbell, Duncan, Woodbury (8)
 Campbell, H. B., 21 Court st., Newark (7)
 Campbell, Wm., 144 Harrison st., E. Orange (7)
 Campbell, Wm. K., 96 Third av., Long Branch (13)
 Cannon, E. A., 5360 Hudson Blvd., N. Bergen (9)
 Cantini, Raphael, 924 Plainfield av., Plainfield (20)
 Cantrell, W. C., 88 Union st., Clifton (16)
 Capuano, Giacinto, 829 S. 4th st., Camden (4)
 Carberry, Edward T., Wharton (14)
 Carbone, Francis R., 157 Hunterdon st., Newark (7)
 Card, Charles F., 54 Elm av., Rahway (20)
 Cardwell, E. P., 15 Fulton st., Newark (7)
 Caridi, Salvatore, 465 Bergenline av., W. N. York (9)
 Carlander, O. R., 1972 Browning rd., M'ch'tville (4)
 Carlin, Edward J., 20 Jacques av., Rahway (20)
 Carlisle, John H., 129 Prospect st., Passaic (16)
 Carlough, D. J., 426 Ellison st., Paterson (16)
 Carman, F. F., 31 Lincoln Park, Newark (7)
 Carmona, Lewis R., Tuckerton (15)
 Carpenter, C. C., 129 Summit av., Summit (20)
 Carpenter, Wm. H., Woodbury (8)
 Carr, Mary B., 1 Astor pl., Jersey City (9)
 Carrigan, Francis P., 288 Franklin av., Nutley (7)
 Carrington, Wm. J., 905 Pac. av., Atlantic City (1)
 Carroll, C. Walter, 117 Center st., Trenton (11)
 Carroll, Edgar, Main st., Dayton (12)
 Carroll, W. V., 211 Academy st., Trenton (11)
 Carstarphan, Wm. T., 819 Park av., Plainfield (20)
 Caruso, Rocco J., 222 Mt. Prospect av., Newark (7)
 Casale, John B., 496 Highland av., Newark (7)
 Casilli, A. R., 618 Newark av., Elizabeth (20)
 Caselman, A. J., 301 N. Second st., Camden (4)
 Cassidy, John M., 1913 Blvd., Jersey City (9)
 Cassidy, S. H., Osborn st., Keyport (13)
 Catanzaro, F., 151 Jefferson st., Passaic (16)
 Cater, Doug. A., 55 Harrison st., East Orange (7)
 Caverly, Fred S., 21 Grove st., Passaic (16)
 Cerone, Daniel M., 398 N. 11th st., Newark (7)
 Chaiken, Louis H., 1024 E. Jersey st., Elizabeth (20)
 Chalfant, H. Bally, Pitman (8)
 Chamberlain, A. R., 30 Lenox pl., Maplewood (7)
 Chamberlain, John L., Sergeantville (10)
 Chapman, E. J., 203 Danforth av., Jersey City (9)
 Chapman, O. P., 270 Morris av., Elizabeth (20)
 Chapman, R. W., 835 Bergen st., Newark (7)
 Charlton, C. C., 124 S. Illinois av., Atlantic City (1)
 Chase, W. E., 587 Main st., Passaic (16)
 Hayes, Sidney, 980 Ave. C, Bayonne (9)
 Chenitz, Wm., 555 Orange st., Newark (7)
 Cherashore, H., 363 Centre st., Nutley (7)
 Chester, Saul W., 264 Graham av., Paterson (16)
 Chew, Elisha C., 603 Pacific av., Atlantic City (1)
 Chianese, C. Chester, 464 Hamilton av., Trent'n (11)
 Chiger, Alex. S., 621 High st., Newark (7)
 Child, F. M., 1222 Bloomfield st., Hoboken (9)
 Child, Florence C., 317 City Hall, Trenton (11)
 Childers, Robt. J., 604 Park av., Plainfield (20)
 Chilton, F. S., Pompton Plains (14)
 Chisholm, Gibbs, 14 Boston st., Newark (7)
 Chmelnik, A. G., 299 Clinton av., Newark (7)
 Christian, Henry A., 111 Fairview av., Jer. City (9)
 Chrisman, Irving, 408 Ellison st., Paterson (16)

- Christian, Thomas B., Greystone Park (14)
 Christensen, A. H., Lebanon (10)
 Ciccone, Anthony C., 389 Grand st., Paterson (16)
 Ciliberti, Frank J., 5th & Pine sts., Camden (4)
 Clark, Charles C., 461 N. Y. av., Union City (9)
 Clark, Ernest W., 209 Haddon av., Westmont (4)
 Clark, Frank G., White House Station (10)
 Clark, John Henry, 108 Orange rd., Montclair (7)
 Clark, S. W., 152 S. N. Carolina av., Atl. City (1)
 Clarke, Edward W., West Englewood (2)
 Clarke, F. W., New st., New Brunswick (12)
 Clarcken, Jos. A., 43 Lincoln Park, Newark (7)
 Clay, Thos A., 351 Totowa av., Paterson (16)
 Clayton, John C., 73 W. Main st., Freehold (13)
 Cleary, Joseph P., Minotola (1)
 Clement, Levina B., 124 Kings hwy., W.H'd'd'nf'd(4)
 Clippinger, R. D., Vineland (6)
 Clock, Ralph O., Pearl River (2)
 Closson, Edward W., Lambertville (10)
 Cloud, A. W., Englewood (2)
 Cobham, Jas. L., 78 Brinkerhoff st., Jersey City (9)
 Coble, Morris S., 102 Wash. st., Perth Amboy (12)
 Coburn, John W., 111 N. Oraton pky., E. Orange (7)
 Cochran, Cleland D., Closter (2)
 Coffin, Henry, 433 Mt. Prospect av., Newark (7)
 Cogan, Henry, 128 Carroll st., Paterson (16)
 Coghlan, Jasper, 17 Academy st., Newark (7)
 Cohen, C. C., 217 W. Hanover st., Trenton (11)
 Cohen, Harry F., 660 Jersey av., Jersey City (9)
 Cohen, Herman, 489 Jersey av., Jersey City (9)
 Cohen, Herman, 1160 Hamilton av., Trenton (11)
 Cohen, Herman N., 714 Park av., Hoboken (9)
 Cohen, Maurice, 106 Valley rd., Montclair (7)
 Cohen, Meyer J., 32 Runyon st., Newark (7)
 Cohen, N. B., 232 State st., Perth Amboy (12)
 Cohen, Samuel A., 112 Mercer st., Jersey City (9)
 Cohen, Sidney L., 20 Avon av., Newark (7)
 Cohen, William, 1007 Greenwood av., Trenton (11)
 Cohn, G. M., 748 S. 10th st., Newark (7)
 Cohn, Herman, 393 Clinton av., Newark (7)
 Cohn, Royal M., 740 Clinton av., Newark (7)
 Cole, Blase, Newton (19)
 Cole, L. Frank, 242 Broadway, Paterson (16)
 Cole, Walter H., 535 Westfield av., Elizabeth (20)
 Coleman, A. H., Clinton (10)
 Coleman, Joseph G., Hamburg (19)
 Colfax, Wm. S., 33 Barthold av., Pompt'n Lakes (16)
 Collier, Martin H., Camden Co. Hosp., Lakel'd (4)
 Collier, Wm. S., 1000 S. Broad st., Trenton (11)
 Collins, H. J., 1160 Hamilton av., Trenton (11)
 Collins, Jas. J., Main st., Woodbridge (12)
 Collins, Lawrence M., Greystone Park (14)
 Colmer, Meyer J., 407 Lyons av., Newark (7)
 Colsh, LeRoy, 612 Ridgewood rd., Maplewood (7)
 Comando, Harry N., 31 Lincoln Park, Newark (7)
 Comeau, George, Morris Plains (14)
 Comfort, John B., 50 S. Clinton av., Trenton (11)
 Communale, A. R., 63 Irving st., Rahway (20)
 Comora, Herman C., 317 16th st., W. New York (9)
 Conaway, Walt P., 1723 Pac. av., Atlantic City (1)
 Condon, John F., 686 Mt. Prospect av., Newark (7)
 Conlon, Philip, 25 James st., Newark (7)
 Connamacher, H. S., 671 Springfield av., Newark (7)
 Connell, Emmet J., 2227 Blvd., Jersey City (9)
 Connell, John, 977 Summit av., Jersey City (9)
 Connell, John N., 26 Carleton av., Jersey City (9)
 Connolly, John A., 212 W. State st., Trenton (11)
 Connolly, John J., 212 Market st., Newark (7)
 Connolly, Richard N., City Hospital, Newark (7)
 Connolly, T. Vincent, 54 Hamilton st., Paterson (16)
 Connolly, Thos. W., 921 Bergen av., Jer. City (9)
 Connor, Clarence A., Fort Lee (2)
 Conoly, J. Holbert, 300 Monmouth st., Gloucester (4)
 Conoly, Lacy N., 601 Walnut st., Camden (4)
 Conty, Anthony J., 318 48th st., Union City (9)
 Cook, H. F., 31 Lincoln Park, Newark (7)
 Cooke, Wm. H., 303 Main st., East Orange (7)
 Cooley, R. L., Dunellen (18)
 Cooney, Chas. J., 121 S. Illinois av., Atl. City (1)
 Cooper, I. J., 90 Livingston av., N. Brunswick (12)
 Cooper, J. Howard, East Millstone (18)
 Cooperman, Wm., 647 Market st., Newark (7)
 Corbusier, H. D., 612 Park av., Plainfield (20)
 Cordasco, P., 48 Glen Ridge av., Montclair (7)
 Corio, George A., 309 Clinton av., Trenton (11)
 Corn, David, Ridgefield Park (2)
 Cornwell, Alfred W., Bridgeton (6)
 Corrigan, Geo. F., 344 Lafayette st., Newark (7)
 Corrigan, Patrick H., 1720 Broad st., Trenton (11)
 Corson, Elton S., Bridgeton (6)
 Corson, Filbert R., 101 S. Indiana av., Atl. City (1)
 Cortese, A. E., 119 Jasper st., Paterson (16)
 Corwin, Theo. W., 671 Broad st., Newark (7)
 Cosgrove, Samuel A., 254 Union st., Jersey City (9)
 Costello, William Francis, Dover (14)
 Costill, Henry B., 371 Hamilton av., Trenton (11)
 *Cotton, Henry A., State Hospital, Trenton (11)
 Cottone, R. J., 683 Princeton av., Trenton (11)
 Cottrell, J. G., 159 Market st., Perth Amboy (12)
 Coughlan, Ella A., 10 Oakwood av., Orange (7)
 Coughlin, Frank J., 594 Kearny av., Arlington (7)
 Coutas, A. B., Madison (14)
 Coward, Edwin H., 1423 Pac. av., Atlantic City (1)
 Cowbeck, H. D., 224 W. State st., Trenton (11)
 Cox, Harold G., Hightstown (11)
 Cox, William W., 27 S. Fullerton av., Montclair (7)
 Crabtree, Loren H., 142 Bellevue av., Elizabeth (20)
 Craig, Henry A., Somerville (18)
 Crain, W. E., Mt. Ephraim (8)
 Crandall, John Kenneth, Fort Lee (2)
 Crane, Bernard, 306 Pacific av., Atlantic City (1)
 Crane, Charles G., 78 Farley av., Newark (7)
 *Crane, J. Welling, State Prison, Trenton (11)
 Craster, Chas. V., 381 Parker st., Newark (7)
 Crawford, Georgiana U., 28 Carnegie av., E. Or. (7)
 Crawford, John W., Bedminster (18)
 Crecca, Wm. D., 111 Park av., Newark (7)
 Cregar, Peter B., 420 Grant av., Plainfield (20)
 Cremens, John F., 144 Carroll st., Paterson (16)
 Crist, W. A., 725 Collings av., W. Collingswood (4)
 Cronin, Francis J., 730 South st., Elizabeth (20)
 Cropper, Chas. W., 2540 Hudson bldv., Jer City (9)
 Cropsey, Charles D., Rutherford (2)
 Crossfield, H. C., 491 S. Orange av., S. Orange (7)
 Crounse, D., 84 Broadway, Passaic (16)
 Crowe, Aldrich C., Ocean City (5)
 Crowley, Jos. W., 4005 Westfield av., Camden (4)
 Crowley, Leo F., 148 Belmont av., Jersey City (9)
 Cryder, Millard, Cape May Court House (5)
 Crystell, E. H., Hillside av., Nutley (7)
 Csema, E. J., 151 Somersset st., N. Brunswick (12)
 Culver, Geo. M., 25 Glenwood av., Jersey City (9)
 Culver, S. Herbert, 75 Magnolia av., Jersey City (9)
 Cummins, G. Wyckoff, Belvidere (21)
 Cunningham, Charles, Jr., Vineland (6)
 Currie, N. W., 503 Central av., Plainfield (20)
 Curry, Marcus A., Greystone Park (14)
 Curtis, Austin M., 445 Van Houten st., Paterson (16)
 Curtis, Donald, Hackensack (2)
 Curtis, Elbert A., 65 Central av., Newark (7)
 Curtis, Frank W., Stewartville (21)
 Curtis, Grant P., 312 36th st., Union City (9)
 Curtis, A. Morris, Moorestown (3)
 Curtis, Howard C., Moorestown (3)
 *Cuskaden, A. D., 5902 Ventnor av., Ventnor City (1)

ASSOCIATE MEMBERS

- Coggiano, A. P., 136 Grove st., Montclair (7)
 Cheskin, L. T., 915 Hunterdon st., Newark (7)
 Chimacoff, H., 171 Elizabeth av., Newark (7)
 Cohen, I. E., 67 Hunterdon st., Newark (7)
 Colton, Ethan T., Jr., 220 Park st., Montclair (7)
 Cowan, Jos. H., 85 Van Reypen st., Jersey City (9)

- D'Acerno, P., 346 Palisade av., Union City (9)
D'Agostin, Henry, Cliffside (2)
D'Arcy, Walter E., 545 E. State st., Trenton (11)
Daggett, E. Hugh, 441 W. Front st., Plainfield (20)
Dalton, S. Eugene, 1616 Pacific av., Atl. City (1)
Daly, Edmund J., 921 Bergen av., Jersey City (9)
Dandois, George F., Wildwood (5)
Dane, Charles, 61 Scotland rd., South Orange (7)
Dane, John, 61 Scotland rd., South Orange (7)
Danzis, Max, 31 Lincoln Park, Newark (7)
Darby, A. Eugene, Ocean City (5)
Darden, Walter T., 149 W. Kinney st., Newark (7)
Darlington, Emlen P., New Lisbon (3)
Darnall, Wm. Edg., 5 S. Morris av., Atl. City (1)
Daron, Simeon, 405 Westminster av., Elizabeth (20)
Davenport, Peter B., 764 S. Orange ave., Newark (7)
Davey, Thomas N., 41 W. 33rd st., Bayonne (9)
Davidson, E. Norwell, 102 Elm st., Linden (20)
Davidson, Harold S., 1616 Pacific av., Atl. City (1)
Davidson, Henry A., 51 Lincoln Park, Newark (7)
Davidson, Louis L., 31 Lincoln Park, Newark (7)
Davies, George A., Elmer (6)
Davies, George W., 35 Fairview av., Verona (7)
Davies, William W., Naval Air Sta., Lakewood (15)
Davis, Albert B., 511 Cooper st., Camden (4)
Davis, E. Vernon, Vincentown (3)
Davis, F. C., 14 Irving pl., Summit (20)
Davis, Harold L., 178 W. State st., Trenton (11)
Davis, Jacob M., Burlington (3)
Davis, Richard M. A., Salem (17)
Davis, Stanton H., 212 E. 7th st., Plainfield (20)
Davis, Wm. Cole, 124 S. Illinois av., Atl. City (1)
Davison, Royden W., 205 W. State st., Trenton (11)
Dawson, Harry E., 618 E. 24th st., Paterson (16)
Day, Grafton E., Frazier & N. J. avs., Coll'gsw'd (4)
Day, Samuel Thomas, Port Norris (6)
Day, Willis B., 154 E. 7th st., Plainfield (20)
Dayton, S. T., Englewood (2)
Deary, Louis E., 31 W. 37th st., Bayonne (9)
De Cesare, F. D., 500 Walnut st., Roselle (20)
Decker, Chas. T., 215 Prospect av., Westfield (20)
Decker, Clinton L., 520 Main st., Boonton (9)
Decker, Henry B., 527 Penn. av., Camden (4)
De Freitas, Clement, 423 W. 4th st., Plainfield (20)
DeFronzo, Morando, 180 Fairmount av., New'k (7)
DeFuccio, C. P., 47 Glenwood av., Jersey City (9)
de Hellebranth, Roland T., 104 S. F'k'd av., V'tnor (1)
Deibert, Irwin E., 618 Benson av., Camden (4)
Deichman, Charles H., Morristown (14)
Delario, A. J., 56 Cross st., Paterson (16)
Del Deo, Nicholas V., 57½ State st., Newark (7)
Del Duca, Vincent, 406 Cooper st., Camden (4)
DelGuercio, O., 342 Clifton av., Newark (7)
Demarest, J. W., Hackensack (2)
Demarest, L. M., 228 S. Orange av., S. Orange (7)
De Mattia, Michael, 71 Cedar st., Paterson (16)
DeMeritt, Chas. L., 415 32nd st., Hoboken (9)
Denelsbeck, J. O., 878 E. State st., Trenton (11)
Denes, O. J., 402 Central av., Nutley (7)
Dengler, H. P., Morris av., Springfield (20)
Denig, R. D., Hackensack (2)
Dennin, Joseph W., 303 Chestnut st., Roselle (20)
Denton, P. P., 951 Madison av., Paterson (16)
DePons, S. C., 501 Grand av., Red Bank (13)
Deriveaux, John A., 103 Clinton av., Newark (7)
De Rosa, Armond, 290 Union blvd., Paterson (16)
De Rosa, John, 150 Fair st., Paterson (16)
De Santo, A. M., Hackensack (2)
DeVausney, Winif'd S., 50 James st., Newark (7)
DeVincintis, Henry, 285 Henry st., Orange (7)
Devlin, Frank, 617 Broadway, Newark (7)
Devlin, Hugh J., 72 Thomas st., Newark (7)
Dexter, Harriet E. T., 903 Ave. C, Bayonne (9)
DeYoe, Leon E., 602 Broadway, Paterson (16)
Dezer, Chas. N., Jr., Englewood (2)
Dias, Joseph L., 17 Lombardy st., Newark (7)
Dickson, J. D., Bogota (2)
Dieker, Howard, 78 Main st., South River (12)
Dieffenbach, R. H., 570 Mt. Prospect av., New'k (7)
Dilger, F. G., Cliffside (2)
Dillingham, W. I., 431 15th st., W. New York (9)
Dinge, Ferd. Chas., 67 S. Munn av., E. Orange (7)
Dingman, N. M., 351 Van Houten st., Paterson (16)
Disbrow, G. Ward, 126 Mountain av., Summit (20)
Disbrow, Harold B., Lakewood (15)
Disbrow, Vanderhoof M., Lakewood (15)
Diverty, Henry B., Woodbury (8)
Dodd, Edw. L., 151 Forest st., Belleville (7)
Dodd, William E., Beach Haven (15)
Dodson, Louis, 592 Jersey av., Jersey City (9)
*Doherty, Wm. J., 201 N. Main st., Pleasantv'e (1)
Dolganos, Moses, 268 Palisade av., Jersey City (9)
Donahue, Wm. J., 173 Roseville av., Newark (7)
Donovan, J., Greystone Park (14)
Donchi, S. M., 400 Belmont av., Newark (7)
Donnelly, Robt. J., 208 W. Market st., Newark (7)
Donohoe, Lucius F., 140 West 8th st., Bayonne (9)
Donovan, William F., Brielle (13)
Doody, Wm. M., 19 Bentley av., Jersey City (9)
Doran, Ralph J., 200 11th st., Hoboken (9)
Doran, Wm. G., 921 Bergen av., Jersey City (9)
Doranz, H. K., 38 S. Hermitage av., Trenton (11)
Doremus, Widmer E., 375 Mt. Prospect av., N'w'k (7)
Dorn, Elliot L., 267 Vassar av., Newark (7)
Dougherty, Daniel D., 206 10th st., Hoboken (9)
Douress, P. C., 802 E. State st., Trenton (11)
Dowd, Ambrose F., 239 Broadway, Newark (7)
Downs, E. Wood E., Woodbury (8)
Downs, Roscius I., Riverside (3)
Draesel, Chas., 230 Webster av., Jersey City (9)
Dragonetti, E. N., 177 Clifton av., Newark (7)
Drake, Daniel E., Gr'nw'd Lake rd., N'w'f'nd'l'nd (16)
Drake, L. B., Ogdensburg (19)
Drake, Paul F., Phillipsburg (21)
Dreskin, J. L., 172 Lyons av., Newark (7)
Driscoll, Chas. D., 213 Clements Br.rd., Barring't'n (4)
Drury, Alfred J., 150 2nd av., E. Roselle Park (20)
*Dubell, John E., Columbus (3)
Dublin, Geo. T., 211 N. 5th st., Camden (4)
DuBois, M. G., 769 High st., Newark (7)
duBusc, L. C. Victor, 399 Westf'd av., Eliz'b'th (20)
Duckett, Warren J., 21 Carlton av., Jersey City (9)
Dukes, Howard R., 220 Kearny av., Kearny (9)
Dulin, Everett K., 144 Harrison st., E. Orange (7)
Duncan, Owsley B., 602 E. 35th st., Paterson (16)
Dundon, A. H., North Plainfield (18)
*Dunlap, Thos. G., 47 S. Virginia av., Atl'tic City (1)
Dunn, John S., Salem (17)
Dunn, Theo. B., 194 Broad st., Bloomfield (7)
Dunning, Walter L., 533 River st., Paterson (16)
Durant, H. J., 526 B'way, Paterson (16)
Durham, Royal E., 114 S. Illinois av., Atl. City (1)
Durrh, F. F., 310 Plainfield av., Plainfield (20)
Dwyer, Henry E., 261 Madison av., Passaic (16)
Dwyer, Wm. A., 99 Park av., Paterson (16)

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- Davis, Thomas C., 16 Old Short Hill rd., Millburn (7)
De Fino, F. J., 463 N. 7th st., Newark (7)
De Fusco, G. T., 330 Newark av., Jersey City (9)
Deignan, Wm. L., 257 Dodd st., E. Orange (7)
Denison, W. C., Ridgewood (2)
Deutel, O. R., 283 Franklin st., Bloomfield (7)
Dranow, Paul, 205 Franklin av., Nutley (7)
Driscoll, Raymond S., 919 Blvd., Bayonne (9)
Dulany, Theo. L., 157 W. Market st., Newark (7)
Eagleton, Wells P., 15 Lombardy st., Newark (7)
Earp, Ruth, Bernardsville (18)
Eason, S. W., 48 DeForrest av., Summit (20)
East, J. Cooper, Skillman (18)
Eaton, Arthur T., 201 4th av., Haddon Heights (4)
Ebenfeld, S. W., 344 High st., Newark (7)
Echikson, Jos. I., 845 S. 12th st., Newark (7)

- Eckert, William, 672 Palisade av., Union City (9)
 Edekrant, Walter L., 82 President st., Passaic (16)
 Edelen, James J., 280 S. Clinton st., E. Orange (7)
 Eckhardt, Ralph A., Madison (14)
 Edgar, Joseph A., 71 Congress st., Jersey City (9)
 Edgar, Malcolm S., 129 Summit av., Summit (20)
 Edelson, Samuel, 1141 Corlies av., Neptune (13)
 Edwards, James B., Leonia (2)
 Edwards, Lena F., 358 Pacific av., Jersey City (9)
 Eigen, Louis A., 368 Gregory av., W. Orange (7)
 Ein, William B., 31 Lincoln Park, Newark (7)
 Eisenberg, D. S., 633 Sanford av., Irvington (7)
 Elias, Elmer, 827 S. Broad st., Trenton (11)
 Elkings, Frank P., Paterson (16)
 Ellenson, S. S., 507 Fourth av., Asbury Park (13)
 Ellis, Alexander, 513 Broadway, Camden (4)
 Ellis, Moury I., 177 S. Clinton st., E. Orange (7)
 Ellmers, B. J., New Milford (2)
 Elmer, Matthew K., Bridgeton (6)
 Elsasser, Theo., 906 Park av., Woodcliff (9)
 Elwell, Alfred M., 407 Cooper st., Camden (4)
 Ely, Lancelot, Somerville (18)
 Emerson, Linn, 310 Main st., Orange (7)
 Emmer, S. Wolfe, 234 Clinton av., Newark (7)
 Emory, G. B., 1 Franklin pl., Morristown (14)
 English, James R., 51 Cypress st., Newark (7)
 English, J. T., 681 Stuyvesant av., Irvington (7)
 English, Samuel B., Glen Gardner (10)
 Enright, J. G., 25 Kensington av., Jersey City (9)
 Epier, Don A., 45 Hillside av., Newark (7)
 Epstein, Harry H., 225 Perry st., Trenton (11)
 Epstein, Henry B., 31 Lincoln Park, Newark (7)
 Erler, Eugene W., 119 N. 5th st., Newark (7)
 Ernest, R. B., 240 W. State st., Trenton (11)
 Ervin, M. B., 572 Prospect st., Maplewood (7)
 Essertier, Edward P., Hackensack (2)
 Etheridge, Chas. E., 479 Prospect st., E. Orange (7)
 Evans, Charles H., 144 Harrison st., E. Orange (7)
 Evans, E. E., Pennsgrove (17)
 Evans, Jas. L., 893 Park av., N. Bergen (9)
 Evans, Winborne D., 2704 Westfield av., Camden (4)
 Ewens, Arthur E., 3600 Pac. av., Atlantic City (1)
 Ewing, Harvey M., 31 Lincoln Park, Newark (7)
 Ewing, Lester H., Berlin (4)
 Eynon, Harold K., 579 Haddon av., Collingsw'd (4)
 Facciolo, Frank, 562 Boulevard, Bayonne (9)
 Fagan, Jas. L., 51 Bayard st., N. Brunswick (12)
 Fager, Rudolph O., 98 Broad st., Bloomfield (7)
 Fahrenbruch, F. D., Mt. Holly (3)
 Failing, Brayton E., 31 Lincoln Park, Newark (7)
 Fairbanks, Warren H., 27 B'way, Freehold (13)
 Faison, John B., 45 Glenwood av., Jersey City (9)
 Falvello, N. A., Morristown (14)
 Fanberg, Sol. J., 31 Lincoln Park, Newark (7)
 Fanelli, Antonio, 469 Lowrie st., Perth Amboy (12)
 Farden, Joseph L., 342 Roseville av., Newark (7)
 Farmer, Vincent, Hackensack (2)
 Farmer, W. D., Allentown (11)
 Farquier, Leonard, 2554 Boulevard, Jersey City (9)
 Farr, Irving L., 214 Walnut st., Montclair (7)
 Farr, W. J., 288 Griggs av., Teaneck (2)
 Farrell, Edgar A., 100 King's H'w'y, W.H'd'n'f'd(4)
 *Farrow, J. Willard, Dover (14)
 Fasano, G., 194 S. 7th st., Newark (7)
 Faughnan, Rose, 97 High st., Passaic (7)
 Faulkingham, R. J., 61 Liv'gst'n av., N. Bruns. (12)
 Favorite, Grant O., West Jersey Hosp., Camden (4)
 Featherston, Dan'l F., 506 4th av., Asbury Park (13)
 Fechner, Julius, 138 W. Kinney st., Newark (7)
 Fee, Elam K., Lawrenceville (11)
 Feher, L. A. M., 196 Somerset st., N. Bruns'w'k (12)
 Feigenoff, I., 420 Broadway, Paterson (16)
 Fein, Bernard, 585 Elizabeth av., Newark (7)
 Feinberg, Harry D., 384 2nd av., Long Branch (13)
 Feit, Herman, 921 Bergen av., Jersey City (9)
 Fell, Alton S., 529 E. State st., Trenton (11)
 Fellman, M., 118 Jewett av., Jersey City (9)
 Fendrick, Edward, 138 Park pl., Irvington (7)
 Fenton, Tennet E., 320 Ludlow av., Spring Lake (13)
 Ferenczi, Louis J., 33 Edwards st., Bayonne (9)
 Ferguson, Chas., 435 Westminster av., Eliz'b'th (20)
 Ferguson, W. E., 1175 Raymond blvd., Newark (7)
 Fern, S. S., 122 Elizabeth av., Newark (7)
 Fessler, A. J., 1544 S. Broad st., Trenton (11)
 Fewsmith, Joseph L., 120 Second av., Newark (7)
 Fiedler, M., 1012 E. Jersey st., Elizabeth (20)
 Field, Frank L., Far Hills (18)
 Fielding, William M., Allendale (2)
 Filkins, Cedric E., 418 W. Horse Pike, Audubon (4)
 Fine, H. P., 185 Market st., Perth Amboy (12)
 Fine, Moses J., 175 Clinton av., Newark (7)
 Fineberg, Jacob, 50 Glenwood av., Jersey City (9)
 Fineburg, Bernard J., 574 Bergen av., Jer. City (9)
 Finegan, P. J., 752 Greenwood av., Trenton (11)
 Finesilver, Ed. M., 31 Lincoln Park, Newark (7)
 Fink, Irving E., 129 Lyons av., Newark (7)
 Finke, Charles H., 317 York st., Jersey City (9)
 Finke, George W., Hackensack (2)
 Finke, John H. D., Hackensack (2)
 Finkel, Joshua, 368 Clinton av., Newark (7)
 Finkelstein, A. S., 174 Johnson av., Newark (7)
 Finkler, Rita S., 99 Lyons av., Newark (7)
 Finn, D. F., Trust Co. Bldg. of N. J., Jer. City (9)
 Finn, Frederick A., 921 Bergen av., Jersey City (9)
 Fischman, H. H., 34 Sterling st., Newark (7)
 Fish, Clyde M., 7 W. Wash. av., Pleasantville (1)
 Fisher, James A., 501 Grand av., Asbury Park (13)
 Fisher, P. C., Ridgewood (2)
 Fisher, Samuel, 808 Madison av., Paterson (16)
 Fisher, Stella C., 4401 Westfield av., Camden (4)
 Fishkoff, A., 360 State st., Perth Amboy (12)
 Fishler, C. F., Clayton (8)
 Pithian, George W., 266 High st., Perth Amboy (12)
 Pitch, Thomas, 744 Watchung av., Plainfield (20)
 Fitzhugh, W. F., Ridgefield Park (2)
 Fitzpatrick, Ed. F., 574 Warren st., Newark (7)
 Flaherty, M. E., 36 Glenwood av., Jersey City (9)
 Flax, J. S., 250 Hawthorne av., Newark (7)
 Fleming, C. L., Pennsgrove (17)
 Flichtenfeld, Morris, 283 4th st., Jersey City (9)
 Fliegel, William, Maywood (2)
 Flint, Edgar T., Raritan (18)
 Flitcroft, William, 510 River st., Paterson (16)
 Flower, M. A., 39 Lincoln Park, Newark (7)
 Flynn, E. A., 161 Washington av., Belleville (7)
 Flynn, Thomas A., Somerville (18)
 Fooder, H. M., Williamstown (8)
 Ford, Theodore R., 19 Prospect st., Summit (20)
 Fordyce, C. P., P. O. Box 322, Westfield (20)
 Forman, Howard S., 640 Bergen av., Jer. City (9)
 Forney, Norman N., Main st., Milltown (12)
 Forsythe, Kenneth C., 530 Summer av., Newark (7)
 Fort, J. Irving, 306 Roseville av., Newark (7)
 Fortunato, J. F., 224 Van Buren st., Newark (7)
 Foster, Frank L., 320 Sp'gfield av., W. Cranf'd (20)
 Foster, Herbert W., 2 Erwin Park, Montclair (7)
 Foster, W. S., 233 Mt. Prospect av., Newark (7)
 Fowler, Royal H., 744 Broad st., Newark (7)
 Fox, J. W., Hillsdale (2)
 Fox, S. W., Ford av., Fords (12)
 Fox, William W., 101 S. Indiana av., Atl. City (1)
 Francis, Adaline M., Somerville (18)
 Frank, Morris, 920 Ave. C, Bayonne (9)
 Frank, Myrtle G., 227 Phila. st., Egg Harbor (1)
 Franklin, C. C., 1012 Hamilton av., Trenton (11)
 Franklin, I. H., 191 Palisade av., Jersey City (9)
 Franklin, Jos. E., 127 Westfield av., Elizabeth (20)
 Franklin, Louis, 191 Palisade av., Jersey City (9)
 Franklin, S. I., Englewood (2)
 Frederick, Gus H., 349 Camden st., Newark (7)
 Freeland, A. J., Woodbine (5)
 Freeland, Frank, Hackensack (2)

Freeman, Geo. C., 1 Lenox pl., Maplewood (7)
 Freeman, Richard D., 103 Scotland rd., S. Orange (7)
 Freile, William, 25 Tonnele av., Jersey City (9)
 Freinkel, Jacob, 2 Hillside av., Newark (7)
 Freidburg, Geo. H., 1139 E. Broad st., Elizabeth (20)
 Friedman, A. I., Little Ferry (2)
 Friedman, H. H., 63 W. Main st., Freehold (13)
 Friedman, Hyman, 1096 Sanford av., Irvington (7)
 Friedman, Milton, Nwk. Beth Israel Hosp., Nwk. (7)
 Friedman, M. H., 526 N. Clinton av., Trenton (11)
 Friedmann, L. L., 484 Princeton av., Trenton (11)
 Friedrich, Adam H., 424 Lafayette st., Newark (7)
 Froelich, J. C., 74 Ingraham pl., Newark (7)
 Frohwein, Ida H., 119 Morrist'n rd., Elizabeth (20)
 Frost, Inglis F., 26 Maple av., Morristown (14)
 Frundt, Oscar C., 92 Bartholdi av., Jersey City (9)
 Fuchs, Jacob N., 1267 S. Broad st., Trenton (11)
 Fuhrmann, Barclay Stokes, Flemington (10)
 Fulper, Theodore B., Hampton (10)
 Funk, Joseph, 615 Elizabeth av., Elizabeth (20)
 Funkhouser, Edgar B., State Hospital, Trenton (11)
 Furlonge, H. Rowland, 333 Forrest st., Jer. City (9)
 Furman, Benj. A., 31 Roseville av., Newark (7)
 Furst, Nathan J., 190 Johnson av., Newark (7)

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 Post, William H., 107 Franklin st., Belleville (7)
 Frank, Nathan, 186 Bowers st., Jersey City (9)
 Freidman, Harry, 721 S. 16th st., Newark (7)
 Frieman, Hyman, 744 Ave. C, Bayonne (9)

Gairdner, T. M., Gibbstown (8)
 Galasso, Attilio, 275 Speedwell av., Morristown (14)
 Gallo, Jas. S., Haledon (1)
 Galloway, Geo. E., 109 Milton av., Rahway (20)
 Gamon, Robert S., 558 Newton av., Camden (4)
 Gandy, Charles M., Ocean View (5)
 Ganley, Arthur J., 390 Park av., East Orange (7)
 Ganot, F. I., 639 Ridge st., Newark (7)
 Gantz, O. E., 215 N. Grove st., E. Orange (7)
 Gardam, J. W., 16 Longfellow av., Newark (7)
 *Gardner, John W., 636 Ocean av., Jersey City (9)
 Garrabrant, Clarence, 19 N. Penn. av., Atl. City (1)
 Garrett, Harry S., Park Ridge (2)
 Garrison, Walter Sherman, Cedarville (6)
 Gauch, William, 177 Elwood av., Newark (7)
 Gauzza, Valentine P., Fords (12)
 Geary, Daniel J., Morristown (14)
 Geary, Paul, 923 Park av., Plainfield (20)
 Geary, Russell D., Riverside (3)
 Geissler, Elmer E., 431 Monmouth st., Glouc't'r (4)
 Gelber, L., 2052 Morris av., Union (20)
 Gelber, L. J., 41 Lincoln Park, Newark (7)
 Gennell, Ernest, 298 Parker st., Newark (7)
 George, M. E. W., 805 Broadway, Newark (7)
 Gerendasy, J., 225 E. Jersey st., Elizabeth (20)
 German, George B., 429 Cooper st., Camden (4)
 Gershenfeld, David B., 20 Hillside av., Newark (7)
 Gesswein, C. A., Church st., Keyport (13)
 Ghee, Euclid P., 115 Clairmont av., Jersey City (9)
 Giambra, S. M., 666 Broadway, Paterson (16)
 Gibb, W. Blake, Madison (14)
 Gibbs, Alice S., 339 Union av., Elizabeth (20)
 Gibson, Chas. F., 1 Summit av., Summit (20)
 Gifford, W. Royal, 247 Park av., East Orange (7)
 Giglio, A. S. V., 626 Elizabeth av., Elizabeth (20)
 Gilady, Ralph, Hackensack (2)
 Gilbertson, R. L., Madison (14)
 Gille, Hugo, 149 Congress st., Jersey City (9)
 Gillson, H. V., 21 Lee pl., Paterson (16)
 Gillson, John T., 170 Broadway, Paterson (16)
 Gilpin, Friend B., 118 North av. W., Cranford (20)
 Ginsberg, Geo., 624 Bloomfield st., Hoboken (9)
 Ginsberg, Samuel, 136 Broadway, Passaic (16)

Gittelman, Morton, 1028 E. Jer. st., Elizabeth (20)
 Gittlesohn, I., Hackensack (2)
 Glaser, E., 218 Marshall st., Elizabeth (20)
 Glasgow, Thos., 120 Passaic av., Passaic (16)
 Glass, Benj. E., 609 Watchung av., Plainfield (20)
 Glass, Oscar, 838 S. 12th st., Newark (7)
 Glass, William H., 144 Harrison st., E. Orange (7)
 Glasston, H. M., 628 N. Wood av., Linden (20)
 Glazebrook, F. H., 6 Altmont ct., Morristown (14)
 Glazer, Edward, 501 Grand av., Asbury Park (13)
 Gleeson, Wm. John, 57 Monticello av., Jer. City (9)
 Glover, Lawrence L., 53 King's Hwy., Haddonf'd (4)
 Gnasso, E. R., Fort Lee (2)
 Gochman, Henry M., 116 Hamilton av., Pat'son (16)
 Godfrey, Allan O., 220 Roseville av., Newark (7)
 Godlin, David R., 610 36th st., N. Bergen (9)
 Goeller, J. D., 1165 W. Clinton av., Irvington (7)
 Goff, Frank J., 64 Maple av., Red Bank (13)
 Goffman, Emanuel, 81 Valley rd., Montclair (7)
 Goldberg, Benj. M., 1156 E. State st., Trenton (11)
 Goldberg, David, Westwood (2)
 Goldberg, H. H., 814 S. 10th st., Newark (7)
 Goldberg, Louis E., 31 Lincoln Park, Newark (7)
 Goldberg, L., 303 N. Washington av., Dunellen (12)
 Goldberg, Samuel A., 46 Farley av., Newark (7)
 Goldberg, Samuel M., 363 Wash. av., Bleeville (7)
 Goldberg, S. M., 353 Washington av., Belleville (7)
 Goldfield, Harold H., 225 E. Jer. st., Elizabeth (20)
 Golding, Harry N., 180 Carroll st., Paterson (16)
 Goldmacher, H. B., 555 S. Broad st., Elizabeth (20)
 Goldstein, A., Lakewood (15)
 Goldstein, Henry Z., 190 Clinton av., Newark (7)
 Goldstein, Hyman I., 1425 Broadway, Camden (4)
 Goldstein, Samuel, 36 W. Main st., Mays Land'g (1)
 Goldstein, Samuel M., 40 Johnson av., Newark (7)
 Goldstein, H. H., 1065 E. Jersey st., Elizabeth (20)
 Goldstein, W. H., 632 Belgrove dr., Arlington (7)
 Goodfellow, G. P., 526 Park av., E. Orange (7)
 Goodrich, S. L., Std. Oil Co. of N. J., Jer. City (20)
 Goodwin, William M., 75 Congress st., Newark (7)
 Gordon, A., 616 Main av., Passaic (16)
 Gordon, A. J., 273 Roseville av., Newark (7)
 Gordon, Charles D., Mt. Arlington (14)
 Gordon, Clark H., 808 E. State st., Trenton (11)
 Gordon, Clifford M., 52 Main st., Paterson (16)
 Gordon, J. B., N. J. State Hosp., Marlboro (13)
 Gordon, Osher, 119 Lexington av., Passaic (16)
 Gordon, William, Blairstown (21)
 Gorezyea, A. G., 538 S. Broad st., Elizabeth (20)
 Gorson, Samuel F., 2005 Pacific av., Atl. City (1)
 Gosling, W. W., 23 Monmouth av., Red Bank (13)
 Goudy, Elmer S., 187 Kearny av., Kearny (9)
 Gould, J. H., 696 Ave. C, Bayonne (9)
 Graddick, Lester W., Morristown (14)
 Grady, Wm. F., 42 N. Fullerton av., Montclair (7)
 Graham, A. F., 42 Park av., Paterson (16)
 Graham, E. E., P. O. Box 195, Yardsville (11)
 Graham, Theo. K., 278 Park av., Paterson (16)
 Gramsch, Louis, Glen Gardner (10)
 Granelli, H. A., 213 Garden st., Hoboken (9)
 Grant, William F., 162 Roseville av., Newark (7)
 Graves, Charles, State Hospital, Marlboro (13)
 Gray, Charles M., Vineland (6)
 Gray, John W., 142 Clinton av., Newark (7)
 Gray, W. B., North Plainfield (18)
 Gregorius, Ralph F., 120 Irvington av., S. Or. (7)
 Gregory, Marie F., Green Village rd., Madison (14)
 Gregory, Mildred G., 21 Roseville av., Newark (7)
 Gregory, R. A., 121 E. 7th st., Plainfield (20)
 Green, David W., Salem (17)
 Green, James S., 463 N. Broad st., Elizabeth (20)
 Greenberg, Geo. A., Somerville (18)
 Greenberg, Philip, 1902 Hudson Blvd., Jer. City (9)
 Greenberg, Samuel, 46 Johnson av., Newark (7)
 Greene, A. D., 195 Palisade av., Union City (9)
 Greenfield, A. W., Hackensack (2)
 Greenfield, W. J., Hackensack (2)

- Greengrass, Jacob J., 146 B'way, Paterson (163)
 Greifinger, Marcus H., 22 Vassar av., Newark (7)
 Greissinger, Karl, 422 20th st., W. New York (9)
 Grier, Robert M., 50 E. Wash'gt'n av., Pl'sntv'le (1)
 Griesmier, Zadoc L., 1143 E. Jer. st., Elizabeth (20)
 Grieve, James, 88 Market st., Perth Amboy (12)
 Griffith, Roy, 909 Broad st., Newark (7)
 *Griffiths, Chauncey B., 105 Park av., E. Orange (7)
 Grimes, Jesse R., Dumont (2)
 Groff, P. A., Little Ferry (2)
 Grossblatt, Philip, 70 Baldwin av., Newark (7)
 Guglielmini, A. D., 449 Hamilton av., Trenton (11)
 Guidi, Guido M., 212 Christine st., Elizabeth (20)
 Guion, Edw., P. O. Box 418, Atlantic City (1)
 Guillion, W. H., 505 Fourth av., Asbury Park (13)
 Guthrie, W. G., 300 Summer av., Newark (7)
 Gutkowski, W. T., 104 Grove ter., Irvington (7)
 Gutmann, Benj., 51 Livingston av., N. Bruns. (12)
 Gutowski, Jos. M., 433 Brace av., Perth Amboy (12)

ASSOCIATE MEMBERS

- Gallo, James F., 32 Zabriskie st., Haledon (16)
 Garibaldi, Louis J., 1016 Hudson st., Hoboken (9)
 Ghee, Peter F., 734 Ocean av., Jersey City (9)
 Golden, Clement H., 81 Seymour av., Newark (7)
 Goldowsky, Ira, 1866 Boulevard, Jersey City (9)
 Griffin, Guy B., 197 S. Centre st., Orange (7)
 Gutman, Edwin K., 980 Summit av., Jer. City (9)
- Hadley, C. F., 201 W. Maple av., Merchantville (4)
 Hagen, Orville R., 266 VanHouten st., Paterson (16)
 Hagerty, John F., 212 W. Market st., Newark (7)
 Haggerty, Daniel L., 227 N. Warren st., Tr'nt'n (11)
 Hagney, Fred W., 669 Elizabeth av., Newark (7)
 Hahn, Katherine B., 272 Thornden st., S. Orange (7)
 Hahn, William, 272 Thornden st., S. Orange (7)
 Haight, Harry W., Raritan av., N. Brunswick (12)
 Haines, Edgar J., Medford (3)
 Haines, Emerson S., 501 Grand av., Asbury Pk. (13)
 Haines, Mabel S., 600 White H'se Pike, Audubon (4)
 Haines, Wm. H., 217 Lafayette av., Audubon (4)
 Haines, W. P., Ocean City (5)
 Halbach, Robert, 513 Main av., Toms River (15)
 Haldeman, Robert E., Mt. Holly (3)
 Hall, Perry O., 254 Union st., Jersey City (9)
 Hall, Winthrop H., 201 Tuttle pkwy., Westfield, (20)
 Hall, W. W., 266 Van Houten st., Paterson (16)
 Hallett, Frederick S., Hackensack (2)
 Halligan, Earl J., 254 Montgomery st., Jer. City (9)
 Halligan, H. J., 254 Montgomery st., Jer. City (9)
 Hallock, W. J., Berkley Heights, Summit (20)
 Halpern, H., Englewood (2)
 Halpern, Samuel, 504 Pacific av., Atlantic City (1)
 Halprin, Harry, 8 Washburn pl., Caldwell (7)
 Halpern, Sophia L., 271 Palisade av., Union City (9)
 Halsey, Levi W., 61 Church st., Montclair (7)
 Halstead, Charles F., Somerville (18)
 Hambricht, A. M., Paterson (16)
 *Hamill, Patrick J., 50 Journal Sq., Jersey City (9)
 Hammer, Walter, 322 15th st., W. New York (9)
 Hammett, Lee J., 760 N. 27th st., Camden (4)
 Hanan, James T., 11 The Crescent, Montclair (7)
 Haney, John J., 167 Cooper st., Trenton (11)
 Hanrahan, J. N., 678 N. Broad st., Elizabeth (20)
 Harden, Albert S., 540 Warren st., Newark (7)
 Hardenberg, D. S., 347 Com'p'w av., Jersey City (9)
 Harhen, Geo. E., 22 Brookside av., Caldwell (7)
 Harley, H. L., 101 S. Indiana av., Atlantic City (1)
 Harmon, Harry M., Frenchtown (10)
 Harman, J. R., 1819 S. Broad st., Trenton (11)
 Harman, Wm. J., 740 W. State st., Trenton (11)
 Harner, M. H., High Bridge (10)
 Harney, J. N., Teaneck (2)
 Harreys, Chas. W., 306 Broadway, Paterson (16)
 Harrington, J. Henry, Rockaway (14)
 Harris, Allen, Greenwich (6)
 Harrison, J. B., 302 E. Broad st., Westfield (20)
- Hart, H. M., 300 Mt. Prospect av., Newark (7)
 Harter, Louis F., 174 Bowers st., Jersey City (9)
 Hartman, Luther, Maple Shade (3)
 Hartwell, H. A., 777 Boulevard East, W'hawk'n (9)
 Harvey, Edwin H., 20 N. Florida av., Atl. City (1)
 Harvey, John W., 818 Ave. C, Bayonne (9)
 Harvey, T. W., 59 Main st., Orange (7)
 Harvey, Thos. W., 59 Main st., Orange (7)
 Haseltine, S. L., 410 Westminster av., Elizabeth (20)
 Hasking, A. P., 318 Montgomery st., Jersey City (9)
 Hasney, Fred'k A., 292 Main st., W. Orange (7)
 Hatch, H. S., Morristown (14)
 Hauck, Lydia B., 644 Stuyvesant av., Irvington (7)
 Hauck, Wm. H., 644 Stuyvesant av., Irvington (7)
 Hausman, S. W., 50 W. Front st., Red Bank (13)
 Haussling, Francis R., 661 High st., Newark (7)
 Haven, Samuel C., 14 Elm st., Morristown (14)
 Hawkes, E. Zeh, 84 Washington st., Newark (7)
 Hawkes, Steuart Z., 84 Washington st., Newark (7)
 Hayden, W. G., 41 Main st., Toms River (15)
 Hays, Roy G., 567 Haddon av., Collingswood (4)
 Haywood, Harry, 3 Elm Row, New Brunswick (12)
 Heath, Louanna, 20 Fairmount av., Newark (7)
 Heatley, William, 335 Broad st., Red Bank (13)
 Hegeman, Runkle F., Somerville (18)
 Heil, A. Arling, Milford (10)
 Heilbrunn, Julius, 135 Belmont av., Jersey City (9)
 Heineken, T. S., 17 Park pl., Bloomfield (7)
 Heinig, Frank G., Boonton (14)
 Heintzelman, B. S., 19 W. 33d st., Bayonne (9)
 Hekimian, J. H., 468 Palisade av., Weehawken (9)
 Helff, J. R., Teaneck (2)
 Heller, G. H., Englewood (2)
 Heller, Nathan B., 31 Lincoln Park, Newark (7)
 Henle, C. B., 671 Springfield av., Newark (7)
 Henry, George, Flemington (10)
 Henshaw, Geo. R., 49 Park ct., Montclair (7)
 Herbener, E. G., Lakewood (15)
 Herman, John H., 197 S. Centre st., Orange (7)
 Hernandez, Manuel, 1974 Hudson Blvd., Jer. C'y (9)
 Herrington, Lee, 147 Central av., Westfield (20)
 Herold, Harvey T., 850 S. 13th st., Newark (7)
 Herold, Herman C. H., 1115 Broad st., Newark (7)
 Herradora, J. R., 921 Bergen av., Jersey City (9)
 Herrman, W. G., 501 Grand av., Asbury Park (13)
 Hersh, David H., 658 Springfield av., Newark (7)
 Hessert, Edmund C., Hadden & Col. avs., C'll'w'd (4)
 Hewson, James S., 163 Myrtle av., Millburn (7)
 Hexamer, Fred, 50 Lyons av., Newark (7)
 Heyman, Arthur, 79 Baldwin av., Newark (7)
 Hicks, William H., 46 Milford av., Newark (7)
 Hiden, J. C., 199 Nassau st., Princeton (11)
 Higgins, G. L., 94 Lembeck av., Jersey City (9)
 Higgins, Thos. A., 2616 Hudson Blvd., Jer. City (9)
 Hilker, George, 463 State st., Perth Amboy (12)
 Hill, J. A., 511 Cedar av., Allenhurst (13)
 Hill, Robert H., 332 Park av., Newark (7)
 Hill, William F., 108 Grand st., Jersey City (9)
 Hillegas, E. J., Mantua (8)
 Hilliard, Ruth, 220 Sussex av., Newark (7)
 Hilliard, William T., Salem (17)
 Hilton, C. O., 598 N. 5th st., Newark (7)
 Hinton, S. H., Parlin (12)
 Hirschfield, B. A., 1404 Greenwood av., Trenton (11)
 Hirst, E. Reed, 586 Federal st., Camden (4)
 Hirst, Levi B., 586 Federal st., Camden (4)
 Hitzeman, Louis A., 30 E. Passaic st., Maywood (2)
 Hnat, Frederick, 450 Rahway av., Elizabeth (20)
 Hoagland, Louis B., Oxford (21)
 Hobart, Richard T., 191 Belleville av., U. Mont. (7)
 Hoeler, Wm. F., 808 S. 11th st., Newark (7)
 Hoffman, Chas. A., 729 Watchung av., Plainf'd (20)
 Hoffman, Florentine M., 91 Bayard st., N. Bruns. (12)
 Hoffman, Peter, 2672 Boulevard, Jersey City (9)
 Hogan, Carlton P., Burlington (3)
 Holden, Edgar, Jr., 217 Broadway, Newark (7)
 Holland, Geo. A., 364 Clinton av., Newark (7)

Holland, John A., 190 W. State st., Trenton (11)
 Holland, Ruben J., Chancellor av., Linden (20)
 Holler, Henry G., 234 Montclair av., Newark (7)
 Hollingshead, Lyman B., Pemberton (3)
 Hollingshed, Beulah S., 600 Benson st., Camden (4)
 Hollingsworth, H. H., 86 First st., Clifton (16)
 Hollinshead, Ralph K., Westville (8)
 Holmes, F. J. E., 151 Fair st., Paterson (16)
 Holmes, George J., 17 Elizabeth av., Newark (7)
 Holmes, Grace A., 1077 E. Jer. st., Elizabeth (20)
 Holoman, M. Browne, 3 N. Granville av., Marg'e (1)
 Holt, Edw. Z., Children's Seaside Home, Atl. C'y (1)
 Holt, Herman H., 285 Graham av., Paterson (16)
 Holters, Otto R., 513 2d av., Asbury Park (13)
 Hommell, P. E., 689 Bergen av., Jersey City (9)
 Hoops, Harold J., 167 Edge av., Jersey City (9)
 Hoover, A. R., 5 Prince st., Elizabeth (20)
 Horn, Max, 94 Lyons av., Newark (7)
 Hornberger, J. Howard, Roebbling (3)
 Horner-Roger, Clara L., 721 Cooper st., Camden (4)
 Hornstine, H. H., Wildwood (5)
 Horowitz, H. J., Morsemere (2)
 Horre, G. W. H., 203 W. Jersey st., Elizabeth (20)
 Horsford, Fred C., 305 Broadway, Newark (7)
 Hosp, Paul H., 842 S. 12th st., Newark (7)
 Houck, Wm. J., 207 Mt. Prospect av., Newark (7)
 Howard, J. E., 67 Kings H'way, W., Haddonfield (4)
 Howell, E. G., New st., New Brunswick (12)
 Howley, B. M., 419 George st., N. Brunswick (12)
 Hubbard, Fayette E., 65 Church st., Montclair (7)
 Hubbard, H. H. V., 121 E. 7th st., Plainfield (20)
 Hubbard, Robt. Y., 58 Myrtle av., Irvington (7)
 Huber, Wm. H., 15 Salem st., Newark (7)
 Huberman, John, 853 S. 12th st., Newark (7)
 Hubert, Tntonio, 133 Main st., Rockaway (14)
 Hudson, Wm. J., 39 W. Wash av., Pleasantv'e (1)
 Huff, Edmund N., Englewood (2)
 Hughes, Frank R., Cape May (5)
 Hughes, Fred'k J., 706 Park av., Plainfield (20)
 Hughes, J. V., 657 Main av., Passaic (16)
 Hughes, Lee W., 965 Broad st., Newark (7)
 Hughes, Thomas E., 223 Cooper st., Camden (4)
 Hulet, Albert G., 20 Hawthorne av., E. Orange (7)
 Hull, D. B., Ridgewood (2)
 Hummel, Ernest G., 414 Cooper st., Camden (4)
 Hummel, L. C., Salem (17)
 Hummel, L. H., Salem (17)
 Hummel, Merwin L., 135 N. Cen. st., M'ch'tv'le (4)
 Humphries, Robt. E., 637 Central av., E. Orange (7)
 Hunt, A. C., 625 Middlesex av., Metuchen (12)
 Hunt, Geo. Halsey, 136 Broad st., Red Bank (13)
 Hunt, M. M., 16 Jackson st., South River (12)
 Hunter, Edward R., Delanco (3)
 Hunter, F. D., Hamilton Square, Trenton (11)
 Hurd, Emerson Freeman, Bound Brook (18)
 Hurff, Joseph W., 86 Washington st., Newark (7)
 Husserl, Siegfried, 777 Clinton av., Newark (7)
 Husted, S. H., Neshanic (18)
 Hutcheson, Chas. R., 517 Cooper st., Camden (4)
 Hutchinson, A. D., 913 W. State st., Trenton (11)
 Hutchinson, G. F., Hamilton Square, Trenton (11)
 Hutton, F. T., 161 Crescent av., Plainfield (20)
 Hyer, Oscar H., Matawan (13)
 Hyman, Charles, 1616 Pacific av., Atlantic City (1)

ASSOCIATE MEMBERS

Hantman, Harold, 49 Farley av., Newark (7)
 Hayes, Gerald W., 96 N. Walnut st., E. Orange (7)
 Horoschak, Anna, Woodbridge (12)
 Hubach, M. F., 202 Broad st., Bloomfield (7)

Iams, Samuel H., 34 Mercer st., Princeton (11)
 Ignatoff, M. L., 493 Central av., Newark (7)
 Ill, Carl H., 188 Clinton av., Newark (7)
 Ill, Charles L., 188 Clinton av., Newark (7)
 Ill, Edgar Alex., 1002 Broad st., Newark (7)
 Ill, Edmund W., 188 Clinton av., Newark (7)

Ill, Edward J., 1004 Broad st., Newark (7)
 Ill, Herbert M., 188 Clinton av., Newark (7)
 Imblcau, J. E. L., Stuyvesant av., Union (20)
 Imhoff, R. E., Moorestown (3)
 Ingling, Harry W., 51 W. Main st., Freehold (13)
 Introcaso, D. A., 45 Crescent av., Jersey City (9)
 Ireland, A. G., N. J. Dept. of Educ., Trenton (11)
 Ireland, Milton S., 23 California av., Atl. City (1)
 Irwin, Jas. R., 330 Washington av., Belleville (7)
 Irwin, J. H., Englewood (2)
 Irvin, John S., 1910 Pacific av., Atlantic City (1)
 Irving, Albert, Albert ct., Radburn (16)
 Ishkhanian, N. J., 656 Palisade av., W. N. York (9)
 Ives, Edward I., 24 Stevens av., Little Falls (16)
 Ivins, W. C., 214 E. Hanover st., Trenton (11)

ASSOCIATE MEMBERS

Israeloff, Howard M., 7 Frederick ter., Irvington (7)

Jack, H. Wesley, 920 Haddon av., Collingswood (4)
 Jacks, Oscar, 476 Mercer st., Jersey City (9)
 Jackson, Albert F., 225 Hillside av., Nutley (7)
 Jackson, Chas. H., 1250 Park Blvd., Camden (4)
 Jacobson, John, 1616 Pac. av., Atlantic City (1)
 Jahn, Albert, Pas. Nat. Bank, Passaic (16)
 Jacob, William H., 99 N. Main av., Paterson (16)
 *Jacobson, Fred C., 1074 Broad st., Newark (9)
 Jacques, J. Eugenia, 74 Waverly st., Jer. City (9)
 Jaffe, Herman, 112 Bergen av., Jersey City (9)
 Jaffin, Abraham E., 41 Emory st., Jersey City (9)
 Jahn, Albert, Pas. Nat. Bank, Passaic (16)
 James, Bart M., 31 Lincoln Park, Newark (7)
 James, Henry C., May's Landing (1)
 James, William H., Pennsville (17)
 James, W. L., Englewood (2)
 Jamison, W. F., 501 Grand av., Asbury Park (13)
 Jani, Frank, 297 Lexington av., Passaic (16)
 Janifer, Clarence S., 208 Parker st., Newark (7)
 Japhe, Nath. M., 190 Clinton av., Newark (7)
 Jarmulowsky, Harry, 237 B'way, Paterson (16)
 Jarrett, Harry, 925 Broadway, Camden (4)
 Jaso, James V., 274 Littleton av., Newark (7)
 Jaspán, Samuel C., 280 Division st., Trenton (11)
 Jedel, Meyer, 125 Fourth st., Newark (7)
 Jentz, John H., 63 Sherman pl., Jersey City (9)
 Jessurun, S. H., 613 High st., Newark (7)
 Joelson, Morris S., 577 B'way, Paterson (16)
 Johnsen, S. W., 49 Passaic av., Passaic (16)
 Johnson, Charles H., 1810 Broadway, Camden (4)
 *Johnson, F. C., 51 Livingston av., N. Brunswick (12)
 Johnson, George, Branchville (19)
 Johnson, G. L., Englewood (2)
 Johnson, H. F., 915 Kensington av., Plainfield (20)
 Johnson, V. Earl, 101 S. Indiana av., Atl. City, (1)
 Jones, Granville L., N. J. State Hosp., Marlboro (13)
 Johnston, R. O., Harrington Park (2)
 Jones, E. C., 75 Midland av., Montclair (7)
 Jones, J. Morgan, Valley rd., R.F.D., Oakland (9)
 Jonitz, Robert, 157 S. Grove st., E. Orange (7)
 Jordan, J. C., 238 E. Main st., Manasquan (13)
 Jordan, W. L., Englewood (2)
 Joseph, B. M., 2771 Boulevard, Jersey City (9)
 Joseph, Morris, 271 Lexington av., Passaic (16)
 Judge, John F., 1009 S. Orange av., Newark (7)
 Jukofsky, I. D., Ridgefield Park (2)
 Just, Francis, 564 High st., Newark (7)
 Justin, A. W., 41 Fulton st., Weehawken (9)
 Justin, J. C., 1074 Dearborn rd., Palisade (9)

ASSOCIATE MEMBERS

Jaffee, Benj., 568 Bergen av., Jersey City (9)
 Jenson, Grover H., 169 Lexington av., Jer. City (9)
 Jost, Franz, 96 Washington st., E. Orange (7)
 Kachdorian, Vartan, 930 Brunswick av., Trent'n (11)
 Kahn, Leo, 4806 Atlantic av., Atlantic City (1)

- Kahrs, Grace M., 375 Mt. Prospect av., Newark (7)
 Kaighn, Chas. B., 905 Pacific av., Atlantic City (1)
 Kain, Thomas M., 403 Cooper st., Camden (4)
 Kain, Wm. W., Cape May C't H'se, R.F.D. 1 (4)
 Kane, Chas. J., 349 Grand st., Paterson (16)
 Kapp, Carl G., 410 Westminster av., Elizabeth (20)
 Karshmer, N., 422 George st., New Brunswick (12)
 Kastler, F., Rutherford (2)
 Kauffman, Louis J., Millville (6)
 Kaufhold, Frank, 41 Leslie st., Newark (7)
 Kaufman, Jerome G., 299 Clinton av., Newark (7)
 Kaufman, M. J., 103 Lycns av., Newark (7)
 Kavanaugh, D. E., 252 Washington av., Bellev'le (7)
 Kay, Clarence R., Peapack (18)
 Kazman, Harold A., 406 B'way, Long Branch (13)
 Kearney, Edward P., 26 Forest st., Montclair (7)
 Keating, C. A., 177 Ellison st., Paterson (16)
 Keegan, Thos. D., 75 Bentley av., Jersey City (9)
 Keim, William F., 25 Roseville av., Newark (7)
 Keir, Floyd E., Englewood (2)
 Keller, F. J., 795 Broadway, Paterson (16)
 Keller, Sidney C., 31 Lincoln Park, Newark (7)
 Kelley, Chas. B., Trust Co. of N. J. Bldg., Jer.C'y (9)
 Kelly, Bernard S., 1954 Blvd., Jersey City (9)
 Kelly, James E., 160 Wegman pky., Jersey City (9)
 Kemeny, Imre, Cartaret (12)
 Kemper, Harry T., 244 Monmouth rd., Elizabeth (20)
 Kennedy, P. A., Englewood (2)
 Kennedy, Wm. M., Essex Co. Sanator'm, Verona (7)
 Kenney, J. A., 132 W. Kinney st., Newark (7)
 *Kent, M. M., 233 N. Warren st., Trenton (11)
 Keppler, Charles, Jr., Allwood rd., Clifton (16)
 Kern, E. Clarence, 45 Park st., Montclair (7)
 Kerns, Francis J., 556 Warren st., Newark (7)
 Kessler, Henry B., 666 Clinton av., Newark (7)
 Kessler, Henry H., 31 Lincoln Park, Newark (7)
 Kieney, C. B., 137 Summit av., Summit (20)
 Kilduffe, Robert A., 5003 Atl. av., Ventnor (1)
 Kiley, Eugene M., 920 Hudson st., Hoboken (9)
 Kim, Gay Bong, 528 Totawa rd., Totawa (16)
 Kinch, F. A., 267 E. Broad st., Westfield (20)
 King, Alden P., over (14)
 King, Chester A., Oradell (2)
 King, George W., Laurel Hill, Secaucus (9)
 Kinney, A. G., 917 Haddon av., Collingswood (4)
 Kinney, Burton O., 41 Lincoln av., Little Falls (16)
 Kinney, S. T., 250 Main st., South Amboy (12)
 Kirby, Cyril S., 98 Broad st., Bloomfield (7)
 Kirkman, Leroy G., 176 Roseville av., Newark (7)
 Kirkwood, Allan S., 53 Union st., Montclair (7)
 Kleiber, Estella, 139 New st., New Brunswick (12)
 Klein, Edward C., Jr., 209 Littleton av., Newark (7)
 Klein, E. F., 136 Market st., Perth Amboy (12)
 *Klein, Ignatz, Newark (7)
 Klein, Wm., 85 Bayard st., New Brunswick (12)
 Kleiner, Samuel, 162 Hamilton av., Paterson (16)
 Klenk, J. P., 328 Belleville av., Bloomfield (7)
 Kler, J. H., Reed st., Stelton (12)
 Kline, Oram R., 414 Cooper st., Camden (4)
 Klugman, Louis W., 375 Ave. C, Bayonne (9)
 Knapp, Richard E., Hackensack (2)
 Knauer, Geo., 930 Elizabeth av., Elizabeth (20)
 Knight, Augustus S., Far Hills (18)
 Knight, I. Warner, Pitman (8)
 Knowles, G. M., Ridgefield Park (2)
 Knowles, James S., Millville (6)
 Knox, C. A., Ridgefield Park (2)
 Knox, Harriet L., Hackensack (2)
 Knox, Howard A., High Bridge (10)
 Koelsch, F. J., Bayard st., New Brunswick (12)
 Koerber, Geo., 136 Prospect st., Passaic (16)
 Kolb, J. M., 725 10th st., Union City (9)
 Kolodon, A., 147 Franklin st., Bloomfield (7)
 Konzelman, H. J., 50 King st., Hillside (20)
 Kooperstein, Samuel, 395 Odgen av., Jer. City (9)
 Koplin, N. H., 142 W. State st., Trenton (11)
 Koppel, Joseph, 921 Bergen av., Jersey City (9)
 Koppel, Leo A., 921 Bergen av., Jersey City (9)
 *Korngut, Samuel, 306 First av., Elizabeth (20)
 Kovarsky, A. E., 255 State st., Perth Amboy (12)
 Kowalski, Louis J., Burlington (3)
 Kraczyk, M. J., 207 Whitehead av., N. Brunsw'k (12)
 Kraemer, Manfred, 186 Clinton av., Newark (7)
 Kraemer, S. E., 121 Market st., Perth Amboy (12)
 Kraissl, C., Englewood (2)
 Kraker, David A., 31 Lincoln Park, Newark (7)
 Kralikauckas, Jos. K., 164 Park pl., Elizabeth (20)
 Krans, Clara DeH., 920 Park av., Plainfield (20)
 Krans, Edw. S., 920 Park av., Plainfield (20)
 Krauss, Emory, Phillipsburg (21)
 Krauss, Fletcher I., Chatham (14)
 Krechmer, Abraham, 521 Pacific av., Atl. City (1)
 Kresch, Philip, 42 W. 22d st., Bayonne (9)
 Kreutz, Paul J., 363 Union av., Elizabeth (20)
 Krichbaum, Carroll E., 63 Myrtle av., Montclair (7)
 Kroll, Adolph, Jr., 103 Van Buren st., Passaic (16)
 Krone, W. F., 31 Lincoln Park, Newark (7)
 Kruger, William, 31 Lincoln Park, Newark (7)
 Kuder, Joseph M., Mount Holly (3)
 Kuhl, Paul E., 48 N. Clinton av., Trenton (11)
 Kuhlmann, Alvin E., 527 37th st., Union City (9)
 Kuite, George B., Morris Plains (14)
 Kummel, M., 315 Central av., E. Newark (7)
 Kunschner, A. J., Milltown (12)
 Kushner, Alexander, 48 Jacques av., Rahway (20)
 Kustrup, J. F., 1435 S. Broad st., Trenton (11)
 Kutner, Chas., 1005 S. 5th st., Camden (4)
- ASSOCIATES
- Kimmel, Seymour, 558A Jersey av., Jersey City (9)
 Klein, Alexander, 210 Market st., Perth Amboy (12)
 Kraemer, Samuel H., 309 Baldwin av., Jer. City (9)
- Laauwe, H. W., 198 Haledon av., Paterson (16)
 Labow, J. J., 1050 E. Jersey st., Elizabeth (20)
 Lafferty, Elton B., 328 Myrtle av., Irvington (7)
 Laird, Geo. S., 127 Central av., Westfield (20)
 *Lambert, F. E., 157 Ocean av., Jersey City (9)
 Lance, E. W., 93 W. Milton av., Rahway (20)
 Landaw, Louis, 583 Broadway, Paterson (16)
 Landesman, Wm., 138 Kearny av., Newark (7)
 Landis, Edwin W., Stillwater (19)
 Lane, Austin W., 98 Prospect st., East Orange (7)
 Lane, E. W., Bloomsbury (10)
 Lane, Frank B., 53 Woodland av., E. Orange (7)
 Lange, Louis C., 50 Clifton ter., Weehawken (9)
 Lansing, T. B., Tenafly (2)
 Largay, Arthur O., 937 Ave. C, Bayonne (9)
 La Riew, Fred J., Washington (21)
 Larkey, Charles J., 700 Ave. C, Bayonne (9)
 *Larkin, Jos. J., 546 Bramhall av., Jersey City (9)
 Larossa, Ernest A., 701 Cooper st., Camden (4)
 Larrabee, C. H., 30 Beechwood rd., Summit (20)
 Larson, H. M., 36 Franklin st., Morristown (14)
 Lathrop, Frederick W., 507 Park av., Plainfield (20)
 Lathrope, Geo. H., 965 Broad st., Newark (14)
 Lavine, B. D., 630 N. Clinton av., Trenton (11)
 Lawrena, Elias W., Paterson (16)
 Lawrence, Minnie J., 83 Second av., Newark (7)
 Lawrence, Wm. H., Jr., 129 Sum. av., Summit (20)
 Lawsing, G. Condi, 443 22d st., W. New York (9)
 Lawton, Anderson A., Somerville (18)
 Leavitt, John F., 522 N. 3rd st., Camden (4)
 LeBel, Louis J. B., 165 Grant av., Nutley (7)
 Lee, Stephen G., 55 Halsted st., East Orange (7)
 Lee, Thomas B., 622 Cooper st., Camden (4)
 LeFavor, Dean H., Palmyra (3)
 Lefkowitz, Jacob H., 445 20th st., W. N. York (9)
 Legato, S., Cliffside (2)
 Leggett, L. H., 330 E. Broad st., Westfield (20)
 Leggett, T. H., Jr., 706 Park av., Plainfield (20)
 Leining, Albert, 1 Fourth st., Weehawken (9)
 Leighton, R. L., 401 Ludlow av., Spring Lake (13)
 Lemay, A. T., 30 Church st., Paterson (16)

- Lemacher, Frank, Lakewood (15)
 Lemmerz, T. H., 141 Magnolia av., Jersey City (9)
 Leonard, E. A., 771 Madison av., Paterson (16)
 Leonard G. F., 63 N. 5th av., New Brunswick (12)
 Leonard, Isaac E., 2842 Atlantic av., Atl. City (1)
 Leonard, Lother L., 615 Asb'y av., Asb'y Park (13)
 Leonardis, J. V., 94 Jefferson st., Newark (7)
 Lepree, Joseph A., 371 Morris av., Elizabeth (20)
 Lerman, I., 1024 E. Jersey st., Elizabeth (20)
 Lettiere, A. J., 320 Centre st., Trenton (11)
 Levendusky, D. E., 52 Market st., Passaic (16)
 Levin, Joseph, 831 S. 13th st., Newark (7)
 Levin, Louis, 140 W. State st., Trenton (11)
 Levin, M. L., 326 Avon av., Newark (7)
 Levine, D. B., 282 Broadway, Paterson (16)
 Levine, E. P., 711 Chancellor av., Irvington (7)
 Levine, G. I., 1861 Boulevard, Jersey City (9)
 Levine, Israel, 215 Broadway, Paterson (16)
 Levinson, L. J., 190 Clinton av., Newark (7)
 Levinson, R. M., 859 S. 13th st., Newark (7)
 Levine, S. C., 459 Park av., Paterson (16)
 Levinsohn, S., 584 B'way, Paterson (16)
 Levitas, Geo. M., Westwood (2)
 Levy, A., Somerville (18)
 Levy, Herman, 219 Lexington av., Passaic (16)
 Levy, Julius, 66 Baldwin av., Newark (7)
 Lewis, Albert, 41 Retford av., Cranford (20)
 Lewis, Alice B., Saddle River (2)
 Lewis, Geo. R., 458 Washington av., Belleville (7)
 Lewis, Livingston L., 712 Wash. st., Hoboken (9)
 Lewis, Thos. K., 47 S. 27th st., Camden (4)
 Leyenberger, S. B., 310 Mt. Prospect av., N'w'k (7)
 Lieberman, David P., 1072 North av., Elizabeth (20)
 Lieberman, Milton L., 1014 E. Grand st., Eliz'b'h (20)
 Lilien, M. M., 162 Gruman av., Hillside (20)
 Linares, A. C., 208 Market st., Paterson (16)
 Linden, Mortimer H., 45 Clendenny av., Jer. C'y (9)
 Lindroth, Lawrence V., 4633 Hud. b'vd., Jer. City, (9)
 Linke, Julian P., 245 E. Front st., Plainfield (20)
 Lippard, Alvin T., 682 Stuyves't av., Irvington (7)
 Lippincott, A. Haines, 406 Cooper st., Camden (4)
 Lipton, L., 67 Passaic av., Passaic (16)
 Little, Alonzo W., 120 Arlington av., Jer. City (9)
 Little, William R., 493 W. State st., Trenton (11)
 Littwin, Charles, Englewood (2)
 Liva, Arcangelo, 5 Pangborn pl., Hackensack (2)
 Liva, P. F., Lyndhurst (2)
 Livengood, B. A., Swedesboro (8)
 Livengood, H. R., 587 Westminster av., Eliz'b'th (20)
 Livingston, Paul, 299 Main st., East Orange (7)
 Lloyd, Reba (Kumpf), Bridgeton (6)
 Lobsenz, N., 294 Broadway, Paterson (16)
 Lodas, George, 1141 E. Jersey st., Elizabeth (20)
 Loder, Horace B., Bridgeton (6)
 Loder, Joseph S., 924 S. 17th st., Newark (7)
 Loeser, Lewis H., 31 Lincoln Park, Newark (7)
 LoMauro, Jas. R., 72 Gron st., Passaic (16)
 London, Wm. M., 256 State st., Perth Amboy (12)
 Londrigan, Joseph F., 535 Wash. st., Hoboken (9)
 Long, Herb. W., 102 Jefferson st., Newark (7)
 Long, Miles T., 2150 Boulevard, Jersey City (9)
 Long, Pauline A., 20 Liv'gst'n av., N. Brunsw'k (12)
 Long, William H., Somerville (18)
 Longbothum, G. T., 208 Dunellen av., Dunellen (12)
 Longsdorf, Harold E., Mount Holly (3)
 Loper, John G., Bridgeton (6)
 Lore, Harry E., Bridgeton (6)
 Losada, Camella A., 19 Prospect st., Summit (20)
 Lottridge, Dorothy, 43 S. Maple av., E. Orange (7)
 Love, Elizabeth F., Moorestown (3)
 Lovell, John F., 1011 Clinton av., Irvington (7)
 Lovett, Jos. C., Municipal Hospital, Camden (4)
 Low, Donald B., 529 Broadway, Paterson (16)
 Lowell, M. E., Skillman (20)
 Lowenstein, H. A., 96 Milford av., Newark (7)
 Lowrey, James H., 79 Congress st., Newark (7)
 Lowy, Otto, 190 Clinton av., Newark (7)
 Luban, Benjamin, 730 High st., Newark (7)
 Lucas, H. H., 266 Van Houten st., Paterson (16)
 Lucas, Stanley L., 1600 Arctic av., Atlantic City (1)
 Lucas, W. Fred., Burlington (3)
 Lucent, S. Bell, Little Falls (16)
 Luczynski, Edward, 38 W. 26th st., Bayonne (9)
 Lueddecke, Rowland E., E. Rutherford (2)
 Lufburrow, C. B., 411 W. Front st., Plainfield (20)
 Luippold, E. J., 85 Columbia ter., Weehawken (9)
 Lumis, M. F., Pitman (8)
 Luminis, C. Percy, Bridgeton (6)
 Lund, John L., 267 High st., Perth Amboy (12)
 Lundblad, Walt. E., 75 Prospect st., E. Orange (7)
 Lupin, Edward E., 727 Ave. C, Bayonne (9)
 Lyerly, J. M., 1116 Putnam av., Plainfield (20)
 Lynch, A. E. O., 257 Orange rd., Montclair (7)
 Lynch, Edw. Thomas, 748 Livingston rd., Eliz. (20)
 Lynch, M. M., Hackensack (2)
 Lynch, Roland J., 93 Fairview av., Jersey City (9)
 Lynn, J. V., Ridgefield (2)
 Lyon, Archibald, 115 Ridge rd., Arlington (7)
 Lyon, C. H., Phillipsburg (21)
 Lyon, Earl Crosby, Bridgeton (6)
 Lyon, Leslie C., P. O. Box 63, Magnolia (4)
 Lyons, James V., 333 Park av., Orange (7)
 Lyons, S. R., Englewood (2)
- ASSOCIATE MEMBERS
- Lazow, S. M., Broad st., Matawan (12)
 Lee, John J., 66 Central av., Orange (7)
 Leir, J. Krevin, 9 Garrison av., Jersey City (9)
 Levitt, Jesse N., 26 Clinton pl., Newark (7)
 Liccese, Emanuel, 98 Jefferson st., Newark (7)
 Licks, Frederick C., 152 Clinton av., Newark (7)
 Liddy, Frank P., Mahwah (2)
 Lisanti, G., 660 Tyler pl., W. New York (9)
 Lynn, Irving I., 272 Banow st., Jersey City (9)
 Macalister, Alexander, 626 Federal st., Camden (4)
 MacAlister, W. W., 333 Van Houten st., Pat. (16)
 MacAlpine, Ken. B., 533 Monm'th st., Gl'c's't'r C'y (4)
 MacArthur, Clymont, 219 Roseville av., Newark (7)
 Macaulay, F. A. Teaneck (2)
 MacDermid, Lynden E., Bordentown (11)
 Macdonald, W. S., 56 Church st., Montclair (7)
 MacDowell, J. L., 112 State st., Perth Amboy (12)
 MacFarland, B. W., Br'd St. B'k Bldg., Tr'nt'n (11)
 MacGregor, A., 379 Ellison st., Paterson (16)
 MacGuffie, R. N., 657 Main av., Passaic (16)
 Mackellar, James M., Tenafly (2)
 MacKenzie, R. A., 501 Grand av., Asbury Park (13)
 MacMillan, Wright, 23 Passaic av., Passaic (16)
 MacPherson, Elwood H., 12 R'wl'y pl., Millburn (7)
 *MacArthur, Chas., 5 Elm st., S. Orange (7)
 McBride, Andrew F., 30 Church st., Paterson (16)
 McBride, Hesser G., 1072 S. Or. av., Newark (7)
 McCabe, Thomas S., 913 Broad st., Newark (7)
 McCallion, Wm. H., 722 Westminster av., Eliz. (20)
 McCamey, Kenneth E., 174 Carroll st., Paterson (16)
 McCandliss, W. K., State Hosp., Trenton (11)
 McCarthy, Arthur M., 2772 Federal st., Camden (4)
 McCarthy, Geo. L., 496 Union av., Paterson (16)
 McCauley, Francis J., 31 Lincoln Park, Newark (7)
 McClintock, Elsie, 1435 Maple av., Hillside (20)
 McCollough, J. H., 523 E. State st., Trenton (11)
 McCollum, A. S., 213 Clements Br. rd., B'r'ring'n (4)
 McConaghy, T. P., cor. 10th & C'p'r sts., Camd'n (4)
 McConaughy, Francis, Somerville (18)
 McCorkle, W. E., Ringoes (10)
 McCormack, F. C., Englewood (2)
 McCormick, Jas. E., 322 Clinton av., Newark (7)
 McCormick, W. H., 266 M'ket st., Perth Amboy (12)
 McCoy, John C., 292 Broadway, Paterson (16)
 McCroskey, J. H., 396 N. Arlington av., E. O. (7)
 McCullough, W. A., Essex Co. Hosp., Cedar Grove (7)
 McDede, Frank F., 922 Main st., Paterson (16)
 McDede, Jos. Searle, 215 Ege av., Jersey City (9)

- McDermott, Vincent, 511 State st., Camden (4)
 McDonald, F. R., 79 Summit av., Jersey City (9)
 *McDonald, J. O., 194 W. State st., Trenton (11)
 McDonald, Richard J., 294 Broadway, Paterson (14)
 McDonnell, G. E., Mt. Holly (3)
 McElhinney, Dennis R., 110 W. Jer. st., Eliz. (20)
 McElroy, Ervin, Rockaway (14)
 McEwen, Floy, 299 Broadway, Newark (7)
 McFeeley, P. R., Bogota (2)
 McGinn, W. J., Front st., Scotch Plains (20)
 McGlade, Thos. H., Camden Co. Hosp., Lakew'd (4)
 McGovern, J. F., 24 Livingston av., N. Bruns. (12)
 McGuigan, F. A., 212 N. Warren st., Trenton (11)
 McGuire, James J., 122 W. State st., Trenton (11)
 McKiernan, Robt. L., 97 Bayard st., N. Bruns. (12)
 McKim, Wm. F., 1044 S. Orange av., Newark (7)
 *McKinstry, Frank P., Washington (21)
 McKinstry, J. W., Jamesburg (12)
 McLane, D. B., Englewood (2)
 McLean, Herbert E., 92 Fairview av., Jer. City (9)
 McLean, Hugh A., 414 17th st., W. New York (9)
 *McLean, John J., 92 Fairview av., Jersey City (9)
 McLellan, Geo. A., 19 Hawthorne av., E. Orange (7)
 McLeod, N. S., Karitan av., Highland Park (12)
 McLoughlin, F. J., 558 Jersey av., Jersey City (9)
 McMahon, Bernard C., Morristown (14)
 McPherson, M. E., 171 Dia. Br. av., Hawthorne (16)
 McVay, Edward A., 234 Lafayette st., Newark (7)
 McVeigh, Charles, Stanhope (19)
- Mabey, J. C., 242 Claremont av., Montclair (7)
 Macchia, Benj. J., 262 Montgomery st., Jer. City (9)
 Mace, Margaret, N. Wildwood (5)
 Macham, Eugene A., 112 Stevens av., S. Amboy (12)
 Maciejewski, A., 212 Van Buren st., Newark (7)
 *Mack, Geo. L., Bound Brook (18)
 Mackes, C. L., Woodstown (17)
 Mack'ler, Louis, 705 Pacific av., Atlantic City (1)
 Mac'ay, Joseph A., 181 E. 33rd st., Paterson (15)
 Madaras, John F., 907 Ave. C, Bayonne (9)
 Madden, Leland S., 221 E. Ver. av., Pleasantville (1)
 Madden, T. W., 16 Frazer av., Collingswood (4)
 Madden, Wm. L., 30 Kensington av., Jer. City (9)
 Mader, A. I., Hackensack (2)
 Magennis, B. C., 170 Hamilton av., Paterson (16)
 Magill, Marcus, 4116 Ventnor av., Atlantic City (1)
 Mahaffey, Jesse L., 414 Cooper st., Camden (4)
 Maher, John E., 90 Third av., Long Branch (13)
 Mahood, H. L., 86 Durand rd., Maplewood (7)
 Mailer, Andrew Robt., 571 Park st., Montclair (16)
 Majeski, H. J., 1015 Brunswick av., Trenton (11)
 Major, Morton M., 2703 Pac. av., Atlantic City (1)
 Makin, John B., 501 Grand av., Asbury Park (13)
 Malatesta, C. S., 741 Kingston av., Plainfield (20)
 Malavazos, Antonio, 635 High st., Newark (7)
 Maldeis, A. M. K., 117 N. 6th st., Camden (4)
 Maliniak, Jacques W., 31 Lincoln Pk., Newark (7)
 Mallalieu, F. W., 16 Monticello av., Jer. City (9)
 Ma'oney, L. F., 156 2nd st., Clifton (16)
 M'mlet, Alfred M., 16 Johnson av., Newark (7)
 Mancusi-Ungaro, E., 270 Mt. Prospect av., Nwk. (7)
 Mancusi-Ungaro, L., 156 Mt. Prospect av., Nwk. (7)
 Mangone, Geo. F., 171 Palisade av., Union City (9)
 Manley, Thomas E., Park av., Paterson (16)
 Mann, Jacob J., 255 State st., Perth Amboy (12)
 Maps, Howard L., 53 Passaic av., Passaic (16)
 Maras, Peter E., 80 Tonnele av., Jersey City (9)
 Marcarian, Henry B., 904 Cooper st., Camden (4)
 Marcus, Jos H., 1148 Fifth av., N. Y. City, N. Y. (1)
 *Marcy, Alexander, Jr., Riverton (3)
 Marcy, John W., 117 E. Park av., Merchantville (4)
 Marini, D., 40 Henry st., Passaic (16)
 Mark, Joseph S., 102 Green st., Woodbridge (12)
 Markel, A., 320 Broadway, Paterson (16)
 Markley, C. A., Teaneck (2)
 Markowitz, B. B., 2157 Blvd., Jersey City (9)
 Markowitz, Irwin, 2157 Boulevard, Jersey City (9)
- Markowitz, Louis, 16 Church st., Paterson (16)
 Marks, David M., 298 4th st., Jersey City (9)
 Marks, Edward G., 655 Kearny av., Arlington (7)
 *Marks, S. J., Bordentown (3)
 Marone, C. R., 648 First av., Elizabeth (20)
 Marotte, Chas. L., 1417 Clinton av., Trenton (11)
 Marquis, Dean W., 132 N. Arlington av., E. Or. (7)
 Marquis, W. James, 198 Clinton av., Newark (7)
 Marshak, Martin I., 679 Ave. C, Bayonne (93)
 Marsh, E. J., 400 Van Houten st., Paterson (16)
 Marshall, Frank A., 200 Jane st., Weehawken (9)
 Marshall, Jos. C., 1517 Pacific av., Atlantic City (1)
 Martin, Wm., 1175 Illinois av., Atlantic City (1)
 Martin, William P., 25 Holland rd., S. Orange (7)
 Martinetti, Carlo D., 311 Central av., Orange (7)
 Martland, Harrison S., 180 Clinton av., Newark (7)
 Marvin, Dorothy, 51 Livingston av., N. Br'sw'k (12)
 Mason, Howard B., 90 W. Main st., Freehold (13)
 Mason, Jas. H. 3d, 1616 Pacific av., Atlantic City (1)
 Massey, J. B., Somerville (18)
 Massey, John F., 20 S. Newport av., Ventnor (1)
 Masucci, A., 34 Ward st., Paterson (16)
 Matera, Joseph, 506 Garden st., Hoboken (9)
 Matheke, O. G., 328 Sussex av., Newark (7)
 Mathesheimer, J. L., 280 Old Bergen rd., Jer. C. (9)
 Matheson, G. E., 649 Central av., E. Orange (7)
 Mathews, R., Morristown (14)
 Mathews, William, 65 Broad st., Red Bank (13)
 Matthews, H. E., 504 Hillside av., Orange (7)
 Matthews, Leonard M., 657 Main av., Passaic (16)
 Matthews, W. F., 11 Seymour av., Montclair (7)
 Matthews, Wm. J., 938 Hudson st., Hoboken (9)
 Maturi, V. E., 814 Boulevard, Bayonne (9)
 Maver, Wm. W., 532 Bergen av., Jersey City (9)
 May, Ernst A., 965 Broad st., Newark (7)
 Mayhew, Charles H., Millville (6)
 Mead, Walter G., 699 Kearny av., Arlington (9)
 Means, P. B., State Hospital, Trenton (11)
 Mears, W. G., Englewood (2)
 Mecray, Paul M., 405 Cooper st., Camden (4)
 Medd, John C., 25 Curtis pl., Maplewood (7)
 Meehan, George Edw., 117 Mercer st., Jer. City (9)
 Meehan, Martin M., 201 Joralemon st., Bellev'le (7)
 Meeker, I. A., 581 Valley rd., Upper Montclair (7)
 Meeker, Frank B., 355 Clifton av., Newark (7)
 Meier, William U., Ringwood av., Haskell (16)
 Meigh, Josiah, Bernardsville (18)
 Meinzer, Martin S., 147 Market st., Perth Amb. (12)
 Meilen, S. H., 863 Mt. Prospect av., Newark (7)
 Meloney, Lester F., 156 2d st., Clifton (16)
 Meltsner, L., 904 Hudson st., Hoboken (9)
 Mendelsohn, D. H., 576 Broadway, Paterson (16)
 Mendelsohn, Lewis, 272 Montgomery st., Jer. C'y (9)
 Mendenhall, Clinton D., Bordentown (3)
 Meneve, A., 87 Bridge st., Paterson (16)
 Mengel, Willard G., 400 Penn. av., Camden (4)
 Menk, Paul E., 31 Lincoln Park, Newark (7)
 *Mentzer, C. A., 42 Hollywood av., Hillside (20)
 Meriwether, E. G., N. J. State Hosp., Trenton (11)
 Merliss, Eugene, 386 Clinton av., Newark (7)
 Merrill, C. F., 16 S. 3d av., Highland Park (12)
 Merselis, John G., 110 Irvington av., S. Orange (7)
 Mersheimer, Chris. H., 15 Reserv'r av., Jer. City (9)
 Messinger, Samuel J., Chrome (12)
 Metsky, Joseph, 777 High st., Newark (7)
 Metzger, Emma P. W., Riverside (3)
 Meuborne, Edw. B., Lawrenceville (11)
 Meurlin, Alfred, 158 Harrison st., E. Orange (7)
 MeVay, Jas. C., 2907 Pacific av., Atlantic City (1)
 Meyer, Edward H., Mahwah (2)
 Meyer, Eugene A., Moorestown (3)
 Meyer, George P., 410 Haddon av., Camden (4)
 Meyer, H. M., 151 Central av., Maywood (2)
 Meyer, Wm., 436 New York av., Union City (9)
 Meyers, F. R., 326 Park av., Paterson (16)
 Meyerson, Noah, 428 15th st., W. New York (9)
 Mial, Leon'das L., 38 Elm st., Morristown (14)

Michela, Luigi S., 206 Carroll st., Paterson (16)
 Michell, George, 221 High st., Hackettstown (14)
 Mierau, E. W., 1096 Sanford av., Irvington (7)
 Miller, D. J. Milton, 7209 Ventnor av., Margate (1)
 Miller, Earle K., 2502 Nottingham way, Tr'n't'n (11)
 Miller, G. H., Cranbury (11)
 Miller, H. Garrett, Millville (6)
 Miller, Jos. A., 364 Prospect st., S. Orange (7)
 Miller, Louis H., Woodstown (17)
 Miller, M. H., 311 16th st., West New York (9)
 Miller, Robt. M., 382 Springfield av., Summit (20)
 Mills, Alvah V., Lindsley rd., Little Falls (16)
 Mills, Charles S., Riverton (3)
 Mills, Clifford, Morristown (14)
 Minard, E. L., 140 4th av., East Orange (7)
 Miner, Donald, 921 Bergen av., Jersey City (9)
 Minier, Carl L., 171 Ellery st., Newark (7)
 Minnefor, C. A., 126 Carolina av., Newark (7)
 Minningham, Wm. D., 18 Hedden ter., Newark (7)
 Mishell, Dan. R., 730 Prospect st., Maplewood (7)
 Mitchell, Augustus J., 59 South st., Newark (7)
 Mitchell, C. H., 1100 W. State st., Trenton (11)
 Mitchell, Chas. R., 311 Broadway, Paterson (16)
 Mitskas, T. V. J., Crosswicks (11)
 Mockridge, O. A., 8 S. Mountain av., Montclair (7)
 Moffat, Barclay W., Nut Swamp rd., Red Bank (13)
 Mohrbacher, John J., 37 Osborne ter., Newark (7)
 Moister, Roger W., 30 Beechwood rd., Summit (20)
 Monasson, Ida, Woodbine (5)
 Monaghan, William J., Secaucus (9)
 Montfort, R. J., 1050 E. Jer. st., Elizabeth (20)
 Moore, Dean C., 73 N. Arlington av., E. Orange (7)
 Moore, John D., 6 Washington av., Bloomfield (7)
 Moore, Ralph L., Woodbury (8)
 Moore, Wm. G., 1576 Mt. Ephraim av., Camden (4)
 Moress, E. J., 1501 Maple av., Hillside (20)
 Morgan, Browne, 260 Liberty st., Bloomfield (7)
 Moriconi, A. F., 438 Hamilton av., Trenton (11)
 Morley, Grace C., 440 Palisade av., Weehawken (9)
 Morris, Carlyle, Metuchen (12)
 Morris, Clement, 513 Broadway, Newark (7)
 Morris, D. G., 11 W. 26th st., Bayonne (9)
 Morris, Thos. M., 503 Park av., Plainfield (20)
 Morris, Watson B., 107 Morris av., Springfield (20)
 Morrison, B. G., Lyndhurst (2)
 Morrison, Caldwell, 379 7th av., Newark (7)
 Morrison, Frederick H., Newton (19)
 Morrison, J. Bennett, 66 Milford av., Newark (7)
 Morrill, Jas. P., 310 Broadway, Paterson (16)
 Mosher, H. L., Lyndhurst (2)
 Motzenbecker, P. F., 31 Lincoln Park, Newark (7)
 Motzenbecker, Wm., 16 Milford av., Newark (7)
 Moulton, Chas. D., 122 Park av., East Orange (7)
 Mount, Elmer M., 74 Sherman pl., Jersey City (9)
 Mount, Walter B., 21 Plymouth st., Montclair (7)
 Mras, J. N., State Hospital, Trenton (11)
 Mravlag, Victor, 1064 E. Jersey st., Elizabeth
 Mueller, Geo. H., 102 Summit av., Jersey City (9)
 *Muellerschoen, Geo. J., 220 S. 16th st., Phila. (1)
 Muldoon, Edward J., Florence (3)
 Mulford, Ephraim R., Burlington (3)
 Muller, F. L., Carlstadt (2)
 Muller, Joseph H., 867 S. 13th st., Newark (7)
 Mulligan, L. A., Leonia (2)
 Mullin, Raymond J., 857 S. 11th st., Newark (7)
 Mullins, R. L., 144 Harrison st., E. Orange (7)
 Munger, Ray T., 727 Watchung av., Plainfield (20)
 Munro, Charles A., Marlton (3)
 Murn, Charles J., 48 Smith st., Paterson (16)
 Murphy, Edward A., 1 Britten st., Jersey City (9)
 Murphy, Herschel, 130 Grant av. E., R'selle Pk (20)
 Murphy, J. A., 467 Hamilton av., Trenton (11)
 Murphy, James M., 2757 Boulevard, Jer. City (9)
 Murphy, Leo J., 374 West st., Union City (9)
 Murphy, P. H. W., 27 Jefferson st., Jersey City (9)
 Murray, H. A., 624 Mt. Prosp. av., Newark (7)
 Murray, Joseph A., 765 Ave. C, Bayonne (9)

Murray, Norman L., 129 Summit av., Summit (20)
 Musetto, Carmelo A., Boonton (14)
 Mustermann, Otto H., 303 48th st., Union City (9)
 Muta, Samuel A., 47 Park av., West Orange (7)
 Muttart, George W., 702 Ocean av., Jersey City (9)
 Mutter, Alfred A., 75 Beach st., Kearny (9)
 Myatt, Leslie E., Bridgeton (6)

ASSOCIATE MEMBERS

Madison, Louis K., 358 Pacific av., Jersey City (9)
 Maggio, George A., 110 Fleming av., Newark (7)
 Magovern, Thomas, 226 S. Orange av., S. Orange (7)
 Mangona, Phillip, 241 S. 7th st., Newark (7)
 Massengill, F., 31 Clinton st., Newark (7)
 Masterson, John F., 94 Myrtle av., Irvington (7)
 Mintz, Abraham, 108 Treacy av., Newark (7)
 Moeckel, C. W., 34 Plymouth st., Montclair (7)
 Moletch, Matthew, Jamesburg (12)
 Mulvihill, Wm. J., 275 Hudson blvd., Bayonne (9)
 Nafash, M. Shafesk, 402 21st st., Union City (9)
 Nafey, Herb't W., 51 Livingston av., N. Bruns. (12)
 Nalitt, David I., 28 W. 33rd st., Bayonne (9)
 Nappi, P. E., 215 Mt. Prospect av., Newark (7)
 Nash, Albert B., 10 S. 13th st., Newark (7)
 Nash, Alexander E., 20 Forest av., Verona (7)
 Nash, Herman S., 865 S. 11th st., Newark (7)
 Nash, Wm. G., 20 Clinton st., Newark (7)
 Nataro, Joseph, 172 Littleton av., Newark (7)
 Natrass, R. B., 204 11th st., Hoboken (9)
 Naulty, C. W., Jr., 403 High st., Perth Amboy (12)
 *Nay, Chas. K., 164 Palisade av., Jersey City (9)
 Neal, Charles B., Millville (6)
 Neare, Clifford B., 2 Hawthorne av., E. Orange (7)
 *Neer, Frank, Paterson (16)
 Neer, William, 245 Broadway, Paterson (16)
 Neiderhoffer, S. L., 189 Monmouth rd., Oakhurst (13)
 Ne'son, Aaron, 462 Jersey av., Jersey City (9)
 Nemzek, W. P. B., 141 Ridge rd., Arlington (7)
 Nesbit, Elizabeth, N. J. Train. School, L. Falls (16)
 Nevin, John, 921 Bergen av., Jersey City (9)
 Newcomb, Marcus W., Brown's Mills (3)
 Newman, Ab'ham J., 70 Sherman pl., Jer. City (9)
 Newman, Grace T., 339 Grove st., Montclair (7)
 Newman, Julius, 10 Osborne ter., Newark (7)
 Newman, Louis G., 316 E. Broad st., Westfield (20)
 Ney, J. Marshall, 78 Clinton av., Newark (7)
 Nichol, L. C., Hackensack (2)
 Nichols, Stanley H., 501 Grand av., Asbury Pk (13)
 Nicholson, Frank, 895 Summit av., Jersey City (9)
 Nicholson, Jos. L., 205 Wash. av., Haddonfield (4)
 Nickman, Harrison, 101 S. Indiana av., Atl. City (1)
 Nieman, S. V., 92 Bayard sh., N. Brunswick (12)
 Niemeyer, C. V., 4610 Boulevard, Union City (9)
 Niemtzow, Frank, 45 E. Main st., Freehold (13)
 Nimaroff, M., 265 Union av., Irvington (7)
 Nittoli, R. N., 660 E. Jersey st., Elizabeth (20)
 Noll, Louis, 1044 Clinton av., Irvington (7)
 North, Harry R., 160 W. State st., Trenton (11)
 Norris, Henry M., 49 Prospect st., E. Orange (7)
 Norton, James F., 299 Varick st., Jersey City (9)
 Novello, Joseph A., 624 4th st., Elizabeth (20)
 Nowrey, Jos. E., Jr., 431 Vine st., Camden (4)
 Nuse, Edward F., 550½ Jersey av., Jersey City (9)
 Nye, Howard H., 174 Broadway, Paterson (16)
 Nyiri, William, 30 Van Ness pl., Newark (7)

ASSOCIATE MEMBERS

Nacca, Carl A., 86 N. Essex av., Orange (7)
 Nevius, Wm. B., 61 N. Fullerton av., E. Orange (7)
 Obert, J. E., New Egypt (15)
 Obester, G. E., 801 E. Jersey st., Elizabeth (20)
 O'Brian, Dennis M., 162 Lexington av., Passaic (16)
 O'Brien, J. H., 204 Madison pl., Passaic (16)
 O'Brien, Paul, East Rutherford (2)

- O'Brien, D. J., 197 Spring st., Portland, Maine (20)
Obuchowski, Henry T., 86 Belmont av., Newark (7)
Ockene, Abraham, 495 Palisade av., Union C'y (9)
O'Connor, B. A., 314 N. 4th st., Harrison (9)
O'Connor, D. F., 671 Broad st., Newark (7)
O'Connor, John J., 434 New York av., Union C'y (9)
O'Connor, M. J., 98 Shanley av., Newark (7)
O'Crowley, Clarence R., 31 Lincoln Park, New. (7)
Oestman, A. W., 932 Summit av., Jersey City (9)
O'Gorman, M. W., 931 Bergen av., Jersey City (9)
O'Hanlon, George, Jersey City Hospital (9)
Okin, I., 23 Passaic av., Passaic (16)
O'Lapnick, M. M., Paterson (16)
Olcott, Geo. P., 144 Harrison st., E. Orange (7)
Older, Benj., 435 N. Y. av., Union City (9)
Oleynick, S., 107 Clinton av., Newark (7)
Olini, Jos. J., 30 W. Market st., Newark (7)
*Oliphant, N. B., 152 W. State st., Trenton (11)
Oliver, David H., Bridgeton (6)
Olpp, Archibald E., 318 Bergenline av., Union C'y (9)
O'Neill, Charles L., 11 N. 7th st., Newark (7)
O'Neill, John H., 270 Montgomery st., Jer. City (9)
Opdyke, C. P., 10 Summit rd., Verona (7)
Opdyke, Gordon McC., 10 Summit rd., Verona (7)
Opdyke, Levings A., 55 Clinton av., Jersey City (9)
Openchowski, M., 52 Jones st., Newark (7)
Opferman, J. L., 167 Bay av., Highlands (13)
Oram, Jos. H., 495 Broadway, Paterson (16)
O'Rourke, Jas. J., 871 Stuyvesant av., Trenton (11)
Orloff, Samuel, 97 Lyons av., Newark (7)
Orton, George L., 98 Elm st., Rahway (20)
Orton, Henry B., 24 Commerce st., Newark (7)
O'Shea, John J., 135 Shippen st., Weehawken (9)
Oshrin, Henry, 750 Park av., W. New York (9)
Osmun, Milton M., 611 Broadway, Camden (4)
*Ost, Henry, 1109-A Broad st., Newark (7)
Ovens, Richard C., 675 Bergen av., Jersey City (9)
*Owen, Fred W., 18 Franklin pl., Morristown (14)
Owen, Logan S., 938 Hudson st., Hoboken (9)
- ASSOCIATE MEMBERS
- Ortolano, James, 522 Garden st., Hoboken (9)
O'Sullivan, John R., 285 Chestnut st., Kearny (9)
- Pacicco, Michele, 376 Monmouth st., Jer. City (9)
Paddock, Royce, 965 Broad st., Newark (7)
Pagliughi, J. J., 401 18th st., Union City (9)
Palm, Howard F., 614 N. 2d st., Camden (4)
Palmer, Francis R., 27 Monroe st., Passaic (16)
Palmer, Gideon H., 28 Winans st., E. Orange (7)
Palmer, H. S., 257 Mulberry st., Newark (7)
Panitch, Wm., 352 Belmont av., Newark (7)
Pannell, W. L., 25 Prospect st., E. Orange (7)
Pannullo, J. N., 266 Van Buren st., Newark (7)
Pansy, Abraham, 12 Jackson st., South River (12)
Pantaleone, J., 504 Hamilton av., Trenton (11)
Parent, Sol., 924 S. 20th st., Newark (7)
Parisi, A., 150 Hunterdon st., Newark (7)
Park, M. B., 360 Park av., Paterson (16)
Parker, John E., 385 Park av., Orange (7)
Parker, H., 72 Norton av., Trenton (11)
Parry, O. K., 601 Bangs av., Asbury Park (13)
Parsonnet, Eugene V., 31 Lincoln Park, Newark (7)
Paul, G. A., 765 Lyons av., Irvington (7)
Payawall, J. L., 170 Broadway, Paterson (16)
Payne, Guy, Overbrook Hospital, Cedar Grove (7)
Payne, Joseph, Midland Park (2)
Pearl, Sidney S., 815 Kilsyth rd., Elizabeth (20)
Pearlstein, F., 325 16th st., West New York (9)
Pedrick, Charles D., Glassboro (8)
Pedrick, William, Glassboro (8)
Peer, Lyndon A., 965 Broad st., Newark (7)
Pellarin, John D., 493 New York av., Union City (9)
Pellett, T. L., Hamburg (19)
Pelusio, August M., 269 Carroll st., Paterson (16)
Pendexter, S. E., 11 S. Arlington av., E. Orange (7)
Pennington, A. W., 1195 Broad st., Bloomfield (7)
Pennington, Geo. P., 12 S. Chelsea av., Atl. C'y (1)
Pennington, J., 101 S. Indiana av., Atl. City (1)
Pentel, Louis S., 307 16th st., W. New York (9)
*Perkins, J. L., 16 Alden st., Cranford (20)
Perlberg, H. J., 921 Bergen av., Jersey City (9)
Pernetti, A. M., 338 6th av., Paterson (16)
Perkel, Louis L., 3263 Boulevard, Jersey City (9)
Perry, Frank L., Woodstown (17)
Pessel, J. F., 224 W. State st., Trenton (11)
Peters, Chas. M., 921 Bergen av., Jersey City (9)
Peters, E. A. P., 394 Bergen av., Jersey City (9)
Peters, Richard C., 923 Park av., Plainfield (20)
Peterson, C. A., 921 Washington st., Hoboken (9)
Peterson, W. R., 224 W. State st., Trenton (11)
Pettit, Herschel, Ocean City (5)
Petry, William, 109 Treacy av., Newark (7)
Phelan, W. F., 124 Chilton st., Elizabeth (20)
Phelps, J. E., 203 Park av., Paterson (16)
Phillbrow, Geo. B., Nutley (7)
Phillips, A. A., 68 W. Market st., Newark (7)
Phillips, Claude B., 891 Haddon av., Collin'w'd (4)
Phillips, R. H. C., 144 W. State st., Trenton (11)
Phillips, Walter, Englewood (2)
Pierson, Carl L., 938 W. State st., Trenton (11)
Pierson, J. R., 224 W. State st., Trenton (11)
Pierson, Theodore A., Hopewell (11)
Pigott, Albert W., Skillman (18)
Pike, Charles E., 411 Newton st., Oaklyn (4)
Pilch, Arthur C., 1 Willard av., Bloomfield (7)
Pilkington, Albert, Amsterdam Apts., Atl. City (1)
Piller, J., 245 Broadway, Passaic (16)
Pinckney, Frank H., Morristown (14)
Pindar, F. S., 960 Park av., N. Bergen (9)
Pindar, W. A., 975 Broadway, Woodcliff (9)
Pino, Anthony, Bridgeton (6)
Pinkerton, Wm. A., 854 Ave. C, Bayonne (9)
Pinneo, Frank W., 439 Mt. Prospect av., New'k (7)
Pinsky, Meyer M., 944 S. 5th st., Camden (4)
Piskorski, A. V., 604 Jersey av., Jersey City (9)
Pitkin, George P., Bergenfield (2)
Pizzi, Francis W., 205 Park av., Orange (7)
Plant, J. S., 467 High st., Newark (7)
Plante, Amos A., 228 Dunnell rd., Maplewood (7)
Platt, Thomas H., 208 Dunellen av., Dunellen (12)
Plavin, Nathan J., 5407 Hud. Blvd., N. Bergen (9)
Plinke, Fritz, 159 Lexington av., Passaic (16)
Plume, Clarence A., Succasunna (14)
Podell, Alfred, 51 E. Front st., Red Bank (13)
Pogoloff, Samuel H., Manville (18)
Poland, Geo. A., 25 E. Wash. av., Pleasantville (1)
Poland, Joseph, 1904 Pacific av., Atlantic City (1)
Polevski, J., 682 High st., Newark (7)
Polizzotti, J. L., 193 Park av., Paterson (16)
Pollak, B. S., Laurel Hill, Secaucus (9)
Pollis, Nicholas, 562 High st., Newark (7)
Polow, Benjamin, 318 Hawthorne av., Newark (7)
Polowe, David, 558 E. 27th st., Paterson (16)
Pomeranz, R., 31 Lincoln Park, Newark (7)
Pontery, Herb't, 89 Bowers st., Jersey City (9)
Pons, C. A., 501 Grand av., Asbury Park (13)
Pooley, Thomas R., Jr., Newton (19)
Potter, Benj. P., Hud. Co. Tub. San., Secaucus (9)
Potter, Ellen C., Glen Cairn Arms, Trenton (11)
Potter, R. T., 144 Harrison st., East Orange (7)
*Potter, Robert C., 25 Fulton st., Newark (7)
Pottinger, W., Mountain Lakes (14)
Povalski, Alex W., 1925 Blvd., Jersey City (9)
*Powell, William R., 702 Market st., Camden (4)
Powis, Ethel M., 198 W. State st., Trenton (11)
Poyas, M. L., 198 W. State st., Trenton (11)
Prager, Bert A., Chatham (14)
Pratt, Arthur C., 515 Cooper st., Camden (4)
*Pratt, John E., Dumont (2)
Pratt, William H., 516 Cooper st., Camden (4)
Pregnall, James P., 501 Grand av., Asb. Park (13)
Preston, Perry B., 12 Palm st., Newark (7)
Price, Nathaniel G., 31 Lincoln Park, Newark (7)

Prinnas, Howard E., 772 Pine st., Camden (4)
 Prigger, E. R., Pennsgrove (17)
 Prince, Robert A., 272 Park av., Paterson (16)
 Principato, Roberto, 402 Walnut st., Camden (4)
 Pringle, F. A., 192 Claremont av., Montclair (7)
 Proctor, Francis E., 12445 Gr'nw'd av., Trenton (11)
 Proctor, James Wm., Englewood (2)
 Protzman, T. B., Englewood (2)
 Prout, Charles, 406 6th av., Asbury Park (13)
 Prout, Thomas P., 19 Prospect st., Summit (20)
 Prout, Wm. B., West Englewood (2)
 Pudney, W. R., 11 Seymour st., Montclair (7)
 Purcell, E. F., 800 Stuyvesant av., Trenton (11)
 Purdy, Chas. H., 35 Highland av., Jersey City (9)
 Pursell, William Dana, Phillipsburg (21)
 Pyle, Louis A., 89 Fairview av., Jersey City (9)
 Pyle, Wallace, 15 Exchange pl., Jersey City (9)

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 Pavia, John R., 365 Chancellor av., Newark (7)
 Payawall, J. L., Ramsey (2)
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 Perham, Bertram S., 199 Loraine av., Up. M'tcl'r (7)
 Pilloni, Louis, 27 Park pl., Bloomfield (7)
 Piltz, Frank, 153 25th st., Guttenberg (9)
 Plain, I. H., 2 Stratford pl., Newark (7)

Quigley, Frederic J., 4622 Boulevard, Union City (9)
 Quinby, W. O'Gorman, 14 James st., Newark (7)
 Quinn, John J., 707 Bergen av., Jersey City (9)
 Quinn, Norman J., 3303 Pac. av., Atlantic City (1)
 Quinn, S. T., 1143 E. Jersey st., Elizabeth (20)
 Quirk, Martin A., 104 Maple av., Red Bank (13)

ASSOCIATE MEMBER

Quad, Clifford W., 53 Northfield av., W. Orange (7)

Radding, M. B., 321 Elmora av., Elizabeth (20)
 Rado, William, 190 Clinton av., Newark (7)
 Rados, Andrew, 299 Clinton av., Newark (7)
 Ragany, Joseph, 966 S. Broad st., Trenton (11)
 Ragoff, George A., 291 Osborne ter., Newark (7)
 Rainey, W. G., 20 Nassau st., Princeton (11)
 Ramos, Nicholas J., 188 Market st., Newark (7)
 Ramsey, F. Muriel, Millville (6)
 Randazzo, Anton P., 82 Prospect st., Passaic (16)
 Randolph, John M., 131 Main st., Rahway (20)
 Ranson, Bris. B. J., 601 Ridgew'w av., Maplew'd (7)
 Rathbone, T. H., 129 Summit av., Summit (20)
 Rathgeber, C. F., 18 William st., E. Orange (7)
 Rathgeber, Wm. M., 249 Roseville av., Newark (7)
 Raughley, William C., Taunton av., Berlin (4)
 Rauschenbach, P. E., 223 Broadway, Paterson (16)
 Ravitz, S. F., 1113 Broad st., Newark (7)
 Rawitz, Sidney B., 31 Lincoln Park, Newark (7)
 Read, Hilton S., Prof. Arts Bldg., Atlantic City (1)
 Read, Jessie D., 228 Jewett av., Jersey City (9)
 Read, William T., 429 Cooper st., Camden (4)
 Reading, Henry E., 538 E. 29th st., Paterson (16)
 Reason, John J., Roosevelt (12)
 Rector, Jos. M., 681 Bergen av., Jersey City (9)
 Reed, F. Grendon, 52 Hill st., Morristown (14)
 Reeves, E., 195 Lexington av., Passaic (16)
 Reeves, J. Franklin, Bridgeton (6)
 Reich, A. L., 83 Lyons av., Newark (7)
 Reich, Henry, 31 Lincoln Park, Newark (7)
 Reich, Jerome J., 1420 Maple av., Hillside (20)
 Reich, S. B., Oradell (2)
 Reid, Erwin W., Garfield (2)
 Reilly, C. J., 321 S. Ninth st., Newark (7)
 Reilly, John V., 472 Sanford av., Newark (7)
 Reiner, Jacob, 811 N. Broad st., Elizabeth (20)
 Reingold, Alex., 221 Garden st., Hoboken (9)
 Reissman, E., 31 Lincoln Park, Newark (7)
 Reitter, G. S., 144 Harrison st., E. Orange (7)
 Renner, Daniel C., 2703 Pacific av., Atlantic City (1)

Renner, Dan Smith, Skillman (18)
 Renzuli, Francesco, 228 S. 7th st., Newark (7)
 RePass, Paul E., 42 Washington st., E. Orange (7)
 Rettig, I. L., 36 Milford av., Newark (7)
 Reynolds, Harry C., 657 Main av., Passaic (16)
 Reynolds, Earle C., 657 Main av., Passaic (16)
 Reynolds, G. G., 64 W. Main st., Freehold (13)
 Rhoads, S. Creadick, Westville (8)
 Rhone, David S., 1202 Haddon av., Camden (4)
 Ribbans, Robert C., 63 Central av., Newark (7)
 Rich, Charles, 191 Littleton av., Newark (7)
 Rich, Harry H., 32 Broad st., Newark (7)
 Richardson, Arthur, 60 Orange rd., Montclair (7)
 Richardson, Charles A., Closter (2)
 Richardson, Emma M., 557 Stevens st., Camden (4)
 *Richardson, Jas. L., New Martinville, W. Va. (1)
 Richie, E. W., Hackensack (2)
 Ricketts, Henry E., 31 Lincoln Park, Newark (7)
 Rieck, Allan, 507 S. Main st., Pleasantville (1)
 Rieck, Walt. R., 379 Kearny av., Kearny (9)
 Rieman, Aloysius, 3566 Boulevard, Jersey City (9)
 Riggs, S. B., 506 Ridgewood av., Glen Ridge (7)
 Riggins, Edwin N., 161 N. Arlington av., E. Or. (7)
 Riardon, J., Rutherford (2)
 Ripley, Charles D., 11 Lincoln Park, Newark (15)
 Ripley, Edward W., 7 Trinity pl., Montclair (7)
 Rippes, Maurice L., 331 Elmora av., Elizabeth (20)
 Ristine, Edwin R., Westville (8)
 Rizzolo, Edward M., 250 Mt. Prosp. av., Newark (7)
 Roak, Jesse L., 454 Bellevue av., Hammononton (1)
 Robbin, Lewis, 18 Clinton pl., Newark (7)
 Robbins, Charles M., 31 Lincoln Park, Newark (7)
 Robbins, Henry B., 144 Mercer st., Jersey City (9)
 Robbins, Warren D., Cape May (5)
 Roberts, D. C., 1536 N. Br'd av., New Orleans, Fla. (7)
 Roberts, Edgar W., 21st & Palisade av., W. N. Y. (9)
 Roberts, Joseph E., Jr., 403 Cooper st., Camden (4)
 Roberts, W. A., 9 Forest av., Caldwell (7)
 Robertson, Grace M., 650 W. 7th st., Plainfield (20)
 Robie, T. R., 452 Richmond av., Maplewood (7)
 Robinson, J. T., Bound Brook (18)
 *Robinson, Moe, 1014 E. Grand st., Elizabeth (20)
 Robinson, Wm. A., 62 Main av., Ocean Grove (13)
 Rocco, F., 729 Summer av., Newark (7)
 Rodi, Louis M., 412 Bellevue av., Hammononton (1)
 Rodman, E. Warren, Beverly (3)
 Roeber, Wm. J., 21 Nesbit ter., Irvington (7)
 Roemer, Jacob, 213 Broadway, Paterson (16)
 Rogers, Alvin S., 126 N. Warren, Trenton (11)
 Rogers, Dorothy, Woodbury (8)
 Rogers, Edwin B., 814 Haddon av., Collinswood (4)
 Rogers, Harry, 144 Harrison st., E. Orange (7)
 Rogers, Harry L., Riverton (3)
 Rogers, L. H., Municipal Colony, Trenton (11)
 Rogers, Richard M. W., 1 Wallace st., Newark (7)
 Rogers, Robert H., 49 Ninth av., Newark (7)
 Rogers, W. N., 1255 Brunswick av., Trenton (11)
 Roh, Robert F., 671 Broad st., Newark (7)
 Rona, Maurice, 159 Bayard st., N. Brunswick (12)
 Roop, W. O., 101 S. Indiana av., Atlantic City (1)
 Rosecrans, J. H., 326 Hudson st., Hoboken (9)
 Rosenberg, Albert B., 1921 Boulevard, Jer. City (9)
 Rosenberg, J., 692 Bergen av., Jersey City (9)
 Rosenberg, L. Charles, 11 Murray st., Newark (7)
 Rosenblatt, S., 1904 Pacific av., Atlantic City (1)
 Rosenstein, Jacob, 568 Bergen av., Jersey City (9)
 Rosenstein, Samuel L., 557 Clinton av., Newark (7)
 Rosenthal, A., 38 Mount st., Atlantic Highlands (13)
 Ross, Alex. S., 542 Cooper st., Camden (4)
 Roth, Oswald H., 210 Littleton av., Newark (7)
 Roth, S. R., 31 Lincoln Park, Newark (7)
 Rothenberg, Samuel, 1 Hillside av., Newark (7)
 Rothhouse, Burnet, 19 Lincoln Park, Newark (7)
 Rothschild, K., 49 Bayard st., New Brunswick (12)
 Rothseid, Abraham, 29 Scherer av., Newark (7)
 Rothstein, I. B., 16 Lyons av., Newark (7)
 Rowan, Henry M., 224 W. State st., Trenton (11)

- Rowe, Norman L., 828 Grand st., Jersey City (9)
 Rowland, J. H., 159 New st., N. Brunswick (12)
 Rowland, John H., 159 New st., N. Brunswick (12)
 Roy, Bert W., Sussex (19)
 Roy, Jos. N., 95 17th av., Paterson (16)
 Rubin, A. David, 401 1st av., Asbury Park (13)
 Rubinow, Saul M., 755 High st., Newark (7)
 Ruch, Louis, Englewood (2)
 Rullman, Walter, 58 W. Front st., Red Bank (13)
 Rumage, Wm. T., 44 Walnut st., Newark (7)
 Rundlett, Emelia V., 79 Prosp. st., Jersey City (9)
 Runnell, J. E., Scotch Plains (20)
 Runyan, Wm. J., 106 Broad st., Bloomfield (7)
 Runyon, L. P., 82 Somerset st., N. Brunswick (12)
 Ruoff, Andrew C., 494 New York av., Union City (9)
 Russell, Charles B., 119 Hamilton av., Paterson (16)
 Russell, David L., 690 Bergen av., Jersey City (9)
 Russell, Edward W., 801 Cooper st., Camden (4)
 Russell, L. C., 192 Clinton av., Newark (7)
 Ruttenberg, Louis, Mantua (8)
 Ruttenberg, Max, 301 Cooper st., Camden (4)
 Ruvane, J. J., 38 Bentley av., Jersey City (9)
 Ryan, John N., 158 Lexington av., Passaic (16)
 Ryley, H. W., East Rutherford (2)
- ASSOCIATE MEMBERS**
- Rineberg, I. E., 93 Bayard st., New Brunswick (12)
 Roberts, A. H., 24 S. 9th st., Newark (7)
 Rosamilia, Robert E., 48 N. 7th st., Newark (7)
 Russomanno, R. L., 181 Clinton av., Newark (7)
- Sacco, Anthony, 440 New York av., Union City (9)
 Sachs, Wilbert, 921 Bergen av., Jersey City (9)
 Sadoff, Joseph, 116 Elmora av., Elizabeth (20)
 Salasin, Samuel L., 511 Pacific av., Atlantic City (1)
 Salsberg, Ralph H., 325 Peshine av., Newark (7)
 Salvati, Leo H., 224 Walnut st., Westfield (20)
 Salzman, Nathan, 714 Broadway, Paterson (16)
 Samuel, Jerome H., 299 Clinton av., Newark (7)
 Sandella, J. F., 169 Nev st., New Brunswick (12)
 Sanfacon, Thomas A., 82 Ward st., Paterson (16)
 Santangelo, Stephen, 304 Varick st., Jer. City (9)
 Santora, Phillip J., 192 Elm st., Newark (7)
 Santosky, Benj. B., 162 Bergen av., Jersey City (9)
 Sarla, Michael, Hackensack (2)
 Saslow, Benjamin, 680 Clinton av., Newark (7)
 Satchwell, H. H., 640 Stuyvesant av., Irvington (7)
 Saunders, O. W., 1700 Broadway, Camden (4)
 Sayre, Wm. D., 69 Maple av., Red Bank (13)
 Sbarra, F., 531 W. Market st., Newark (7)
 Scammell, F. G., 40 S. Clinton av., Trenton (11)
 Scanlan, David W., 15 S. Ill. av., Atlantic City (1)
 Scasserra, B. B., 110 Nassau st., Trenton (11)
 Schaaf, Royal A., 413 Mt. Prospect av., Newark (7)
 Schaefer, E. P., 12 Harrison pl., Irvington (7)
 Schaffer, Nathan, 94 S. Munn av., E. Orange (7)
 Schapiro, Jos., 712 Palisade av., Union City (9)
 *Schauffler, W. G., 21 Morven pl., Princeton (11)
 Schectman, Vera, 385 Osborne ter., Newark (7)
 Scheffler, W. A. H., 511 Cooper st., Camden (4)
 Schellenger, E. A. Y., 429 Cooper st., Camden (4)
 Schenk, Jos. R., 1175 Park av., Plainfield (20)
 Schenker, B. N., 246 5th st., Jersey City (9)
 Schept, S. S., 523 37th st., Union City (9)
 Schildkraut, J. M., 170 W. State st., Trenton (11)
 Schiller, Nicholas, 9 Pierce st., Newark (7)
 Schimmelpfenning, R. D., 258 Cl'rem't av., M'tcl'r (7)
 Schisler, Milton M., Florence (3)
 Schlein, August, 707 Park av., Hoboken (9)
 Schlichter, C. H., 556 N. Broad st., Elizabeth (20)
 Schmidt, Albert F., 81 Union st., Manasquan (13)
 Schmidt, Hilmar R., Lincoln Park (14)
 Schmidt, Walter W., Cliffside Park (2)
 Schmitz, Mathias, Denville (14)
 Schmukler, Jacob, 29 Rutgers st., Maplewood (7)
 Schneekendorf, S., 179 Harrison av., Jersey City (9)
 Schneider, C. A., 694 Clinton av., Newark (7)
 Schneider, Louis, 874 S. 13th st., Newark (7)
 Schneider, Louis A., 412 17th st., West N. Y. (9)
 Schrack, Helen F., 216 N. 5th st., Camden (4)
 Schramm, Joseph A., 23 Darcy st., Newark (7)
 Schreck, Harry, 139 Roseville av., Newark (7)
 Schroeder, H. J. L., 134 W. State st., Trenton (11)
 Schruggs, W. J., 3005 Kearsage rd., F'r'v'w, Cam. (4)
 Schuchner, Wm. F., 264 First st., Jersey City (9)
 Schulman, A. S., 4638 Hudson blvd., Union City (9)
 Schulsinger, S., 48 Walnut st., Newark (7)
 Schulte, H. A., 701 Clinton av., Newark (7)
 Schultz, A. M., 379 Union av., Paterson (16)
 Schuck, Traugott E., 58 9th st., Hoboken (9)
 Schurman, E. W., 710 Ocean av., Jersey City (9)
 Schwartz, Henry C., Atco, N. J. (4)
 Schwartz, Henry C., Atco (4)
 Schwartz, Samuel H., 414 Park av., Plainfield (20)
 Schwarz, B. T. D., 2801 Hudson Blvd., Jer. City (9)
 *Schwarz, W. J. A., 269 Cator av., Jersey City (9)
 Schwarzkopf, Geo., 2900 Pacific av., Atlantic City (1)
 Schweitzer, Roman G., 860 E. Jersey st., Eliz. (20)
 Scielzo, M. F., 777 Madison av., Paterson (16)
 Sciorsci, Edward P., 609 Bloomfield st., Hoboken (9)
 Scott, F., Franklin (19)
 Scott, E. A., Belle Mead San., Belle Mead (13)
 Scott, Fred W., 103 Bayard st., New Brunswick (12)
 Scott, Harold R., Morristown (14)
 Scott, Karl M., Prof. Arts Bldg., Atlantic City (1)
 Scott, Parry M., Beverly (3)
 Scott, R. Hunter, 205 Roseville av., Newark (7)
 Scott, Samuel G., 141 Bergen av., Jersey City (9)
 Seranton, Chas. W., 31 Washington st., E. Or. (7)
 Scribner, Charles H., Hamberg Tyke, Paterson (16)
 Scudder, F. D., 63 S. Fullerton av., Montclair (7)
 Sealey, H. J., Dumont (2)
 Seely, Roy, 78 N. Clinton st., Trenton (11)
 Seidler, William F., 29 Rossmore pl., Belleville (7)
 Seidler, V. B., 16 Plymouth st., Montclair (7)
 Seidman, E. A., 580 High st., Newark (7)
 Seidman, Marcus, 580 High st., Newark (7)
 Seifert, Edwin A., 247 Claremont av., Montclair (7)
 Seitzick, Hannah E., 733 Hamilton av., Trenton (11)
 Sekerak, Albert J., 977 S. Broad st., Trenton (11)
 Selinger, Samuel, 413 16th st., W. New York (9)
 Sell, Frederick W., 113 Commerce st., Rahway (20)
 Sellers, Robt. R., 19 Chestnut st., Newark (7)
 Sena, Marie, 303 Anderson av., Fairview (9)
 Sender, Fannie, 191 Whitehead st., South River (12)
 Senseman, Theo., 3600 Pac. av., Atlantic City (1)
 Sesta, Joseph, 242 Fulton av., Jersey City (9)
 Sewall, Millard F., Bridgeton (6)
 Seward, Wm. H., Madison (14)
 Sexsmith, George H., 719 Ave. C, Bayonne (9)
 Seybold, Arthur D., 302 E. 7th st., Plainfield (20)
 Seymour, Geo. A., 253 Orchard st., Elizabeth (20)
 Seymour, E. T., Tenafly (2)
 Sferra, Alfred F. W., Bound Brook (18)
 Shaefer, C. P., 241 Kings Hwy. E., Haddonfield (4)
 Shafer, Alfred H., 405 Cooper st., Camden (4)
 Shafer, Fred'k W., 634 Penn av., Camden (4)
 Shangle, Milt A., 34 Prince st., Elizabeth (20)
 Shannon, J. B., 56 Church st., Montclair (7)
 Shapiro, Charles S., Maple Shade (3)
 Shapiro, David Passaic
 Shapiro, L. G., 375 Broadway, Paterson (16)
 Shapiro, Maurice, 750 Ave. C, Bayonne (9)
 Shapiro, N. J., 192 Palisade av., Union City (9)
 Sharp, Charles E., Port Morris (6)
 Sharp, R. L., 726 Cooper st., Camden (4)
 Shaul, F. G., 10 Washington st., Bloomfield (7)
 Shaw, Ernest B., 811 Collings av., Collingswood (4)
 *Shaw, Harry English, Long Branch (13)
 Shaw, Joseph B., 119 S. Warren st., Trenton (11)
 Sheeran, V. J., 269 Jewett av., Jersey City (9)
 Sheets, C. C., Paulsboro (8)
 Shemeley, Wm. C., Jr., 7 Haddon av., Camden (4)
 Shenfeld, Isaac, 4806 Ventnor av., Ventnor (1)

- Sheppard, Frank R., Millville (6)
 Sherk, A. Lincoln, 2647 Westfield av., Camden (4)
 Sherlock, Marg't E., Vinel'd State Sch'l, Vinel'd (18)
 Sherman, Alton L., 26 Northfield av., W. Orange (7)
 Sherman, A. Russell, 671 Broad st., Newark (7)
 Sherman, Byron G., Maple av., Morristown (14)
 Sherman, Elbert S., 671 Broad st., Newark (7)
 Sherman, Fuller G., Woodbury (8)
 Sherman, Samuel H., 81 Elmora av., Elizabeth (20)
 Sherman, W. E., Geo. & Schureman, N.Br'nsw'k (12)
 *Sherron, Clifford M., Salem (17)
 Shill, Benjamin, 131 Renner av., Newark (7)
 Shimer, A. Burton, 606 Pac. av., Atlantic City (1)
 Shimer, Floyd A., Phillipsburg (21)
 Shipman, Frank C., 3663 Boulevard, Jersey City (9)
 Shipman, Jas. S., 542 Cooper st., Camden (4)
 Shippe, David M., Midvale (16)
 Shippes, Hammel P., Delanco (3)
 Shirrefs, Russell A., 55 Broad st., Elizabeth (20)
 Shivers, C. H. deT., 121 S. Ill. av., Atlantic City (1)
 Shockley, Francis M., 144 Har'n st., E. Orange, (7)
 Shope, E. P., 956 Newton av., Camden (4)
 Shor, David M., 32 S. Munn av., E. Orange (7)
 Shull, E. C., 517 Cooper st., Camden (4)
 Shulman, Abraham, 528 E. 29th st., Paterson (16)
 Shulman, N. L., 538 45th st., Union City (9)
 Sica, Samuel, 431 E. State st., Trenton (11)
 Sieber, Isaac G., 204 Merchant st., Audubon (4)
 Siegel, J. W., 96 S. 10th st., Newark (7)
 Siegler, Julius, 646 Bergen av., Jersey City (9)
 Sieveke, J., 106 Lexington av., Passaic (16)
 Silk, Chas. I., 189 Rector st., Perth Amboy (12)
 Sill, John B., 942 W. State st., Trenton (11)
 Silver, E. Drew, Hightstown (11)
 Silver, George A., Hightstown (11)
 Silver, H. B., 190 Clinton av., Newark (7)
 Silvers, Homer I., 16 S. Suffolk av., Ventnor (1)
 Silverstein, Benj. J., 32 Hillside av., Newark (7)
 Silverstein, J. M., 73 Main st., Millburn (7)
 Simeone, Peter A., 555 38th st., Union City (9)
 Simmons, Albert V., 720 Prospect st., Maplew'd (7)
 Simms, Geo. F., 541 Page st., Lyndhurst (7)
 Simon, Ludwig, 201 Ferry st., Newark (7)
 Simon, Morris L., 174 Washington pl., Passaic (16)
 Simpkins, Raymond, Bridgeton (6)
 Sinexon, Harry L., Paulsboro (8)
 Singer, Max, 147 Johnson av., Newark (7)
 Sinkinson, Chas. D., Jr., 1616 Pac. av., Atl. City (1)
 Sinton, John Y., Imlaystown (11)
 Sirken, Chas., 887 Summit av., Jersey City (9)
 Sirott, Barnett H., 409 State st., Perth Amboy (12)
 Sista, Charles R., 476 Hamilton av., Trenton (11)
 Skinner, William F., Washington (21)
 Skwirsky, Jos., 170 Hawthorne av., Newark (7)
 Slack, Clarence J., 230 W. State st., Trenton (11)
 Slaff, F., 16 Grove st., Passaic (16)
 Slavin, Paul, Glen Gardner (10)
 Sloan, Samuel L., 182 Belmont av., Paterson (16)
 Slobodien, Benj. F., 107 Market st., Perth Amboy (12)
 Slocum, Harry B., Bath av., Long Branch (13)
 Sly, John L., 382 Springfield av., Summit (20)
 Smaine, E. C., Rutherford (2)
 Small, E. Lester, Medford (3)
 Smalley, Mahlon C., Peapack (18)
 Smalley, Sara D., 530 Clifton av., Newark (7)
 Smith, Alexander L., 2672 Blvd., Jersey City (9)
 Smith, A. L. M., 62 Bayard st., New Brunswick (12)
 Smith, Andrew M., 344 Phila. st., Egg Harbor (1)
 Smith, Byron J., 79* S. Orange av., Newark (7)
 *Smith, Charles B., Washington (21)
 Smith, E. L., Soho Hospital, Belleville (7)
 Smith, E. W., 657 Main av., Passaic (16)
 Smith, G. H., 136 Evergreen pl., E. Orange (7)
 Smith, Harold W., 179 Clinton av., Orange (7)
 Smith, H. G., Cedar Grove (7)
 Smith, Houghton, 1063 S. Clinton av., Trenton (11)
 Smith, James D., 701 N. 6th st., Camden (4)
 Smith, J. Vincent, 463 State st., Perth Amboy (12)
 Smith, J. J., 325 13th av., Newark (7)
 Smith, Leon A., 72 Grove st., Passaic (16)
 Smith, L. H., 32 Washington st., E. Orange (7)
 Smith, Marcia V., Ocean City (5)
 Smith, M. K., Morristown (14)
 Smith, T. A., Short Hills (7)
 Smith, Warren H., Newton (19)
 Smith, W. Henly, 34 W. State st., Trenton (11)
 Snavelly, Earl H., City Hosp., Newark (7)
 Snedecor, S. T., 50 Anderson st., Hackensack (2)
 Snyder, J. E. C., 1023 Garden st., Hoboken (9)
 Sobin, Julius, 24 Waverly av., Newark (7)
 Somers, Fred L., 144 Harrison st., Orange (7)
 Sommer, G. N. J., 120 W. State st., Trenton (11)
 Soschin, Samuel J., 299 Clinton av., Newark (7)
 Sosnow, L. M., Hillsdale (2)
 Spalding, H. J., 512 45th st., Union City (9)
 Spallone, Jos. C., 123 Mt. Prospect av., Newark (7)
 Spano, Frank, 320 47th st., Union City (9)
 Spath, George B., 722 Hudson st., Hoboken (9)
 Speer, John U., N. Y & Sunny aves., Somers Pt. (1)
 Spence, Henry, 2540 Boulevard, Jersey City (9)
 Spencer, Alvan, 19 E. Blackwell st., Dover (14)
 Spencer, John H., Newton (19)
 Spencer, Ira T., Main st., Woodbridge (12)
 Spickers, William, 6 Church st., Paterson (16)
 Spillane, T. H., Phillipsburg (21)
 Sprague, Edw. W., 86 Washing'tn st., Newark (7)
 Sprague, Seth B., 301 York st., Jersey City (9)
 Spurgeon, D. L., Newton (19)
 Staehle, Richard H., 34 Lyons av., Newark (7)
 Stahl, Alfred, 55 Lincoln Park, Newark (7)
 Stahl, Charles, 659 Sanford av., Newark (7)
 Stamps, G. Ruffin, 214 E. Verona av., Plea'v'le (1)
 Stanton, Nath. B., 734 Park av., Plainfield (20)
 Stark, Jacob
 Stark, M., 557 Broadway, Paterson (16)
 Staub, E. Milton, 531 E. Broad st., Westfield (20)
 Steadman, E. T., 107 Christopher st., Montclair (9)
 Steele, Stephen, 500 Wood av., Linden (20)
 Steffen, Charles T., Dunellen av., Dunellen (12)
 Stein, Emil, 607 Park av., Elizabeth (20)
 Stein, George H., 411 Westm'ter av., Elizabeth (20)
 Stein, Harry M., 227 W. Broadway, Paterson (16)
 Stein, Isadore, 210 Elizabeth av., Elizabeth (20)
 Stein, Jacob M., 68 Columbia ter., Weehawken (9)
 Stein, Joseph M., 1004 Newton av., Camden (4)
 Stein, L. A., 205 Market st., Trenton (11)
 Stein, Martin H., 163 2d st., Elizabeth (20)
 Steinberg, Benj. Louis, Four Corners, Singac (16)
 Steiner, Edwin, 19 Lincoln Park, Newark (7)
 Stephenson, G. A., Jersey City Hosp., Jer. City (20)
 Stern, Arthur, 224 E. Jersey st., Elizabeth (20)
 Stern, Samuel, 2815 Pacific av., Atlantic City (1)
 Stevens, J. Thompson, 55 Park st., Montclair (7)
 Stevenson, A. M., 7506 Ventnor av., Ventnor (1)
 Stevenson, Geo. S., Red Bank (13)
 Steuart, David T., 10 De Barry pl., Summit (20)
 Stewart, Irving J., Swedesboro (8)
 Stewart, Robt. G., 79 Midland av., Montclair (7)
 Stewart, Walter B., 8 N. Tal'h's'e av., Atl. C'y (1)
 *Stewart, W. Blair, Pac. & N. Car. ave., Atl. City (1)
 Stickles, Llcyd C., 49 Parkhurst st., Newark (7)
 Stillwell, Aaron L., Somerville (18)
 Stillwell, H. C., 70 Irving pl., Rahway (12)
 Stimis, H. G., 300 Kalghn av., Camden (4)
 Stinson, Richard, 641 E. 18th st., Paterson (16)
 Stockfish, Robt., 3644 Boulevard, Jersey City (9)
 Stokes, Earl B., 725 High st., E. Orange (7)
 Stokes, Joseph, Moorestown (3)
 Stokes, Samuel Emlen, Moorestown (3)
 Stoltz, R. R., 23 Passaic av., Passaic (16)
 Stone, A. L., 2838 Berkley st., Camden (4)
 Stone, Frank R., Laurel rd., Laurel Spgs., (4) Pat.
 Stone, R. G., State Hospital, Trenton (11)
 Stout, Harry Wilson, Wenonah (8)

- Stout, J. Phillip, 165 Jewett st., Jersey City (9)
 Strahan, F. G., 473 Broadway, Long Branch (13)
 Strandberg, H., 94 Wash. av., Carteret (12)
 Straub, H. H., 242 Springdale av., E. Orange (7)
 Straughan, C. C., 23 Monmouth st., Red Bank (13)
 Strauss, Arthur, 130 Pavil. av., Long Branch (13)
 Street, D. B., 27 Woodlawn av., Jersey City (9)
 Strelinger, Edward A., 4800 Walnut st., Phila. (20)
 Strickland, G. W., 123 First av., Roselle (20)
 Strom, A., 410 W. 7th st., Plainfield (20)
 Stuart, A. A. S., Ridgefield Park (2)
 Stuart, J. Earley, 552 E. Second st., Plainfield (20)
 Stuart, W. C., 518 Hudson st., Hoboken (9)
 Subin, Harry, 1616 Pac. av., Atlantic City (1)
 Succoff, Moses C., 158 Hamilton av., Passaic (16)
 Sullivan, Chas. J., 57 Paterson st., New Bruns. (12)
 Sullivan, George F., 510 Hudson st., Hoboken (9)
 Sullivan, James A., 668 Jer. av., Jersey City (9)
 Sullivan, Margaret N., 70 Undercliffe rd., M'tcl'r (9)
 Sulouff, S. Henry, 662 Newark av., Jersey City (9)
 Summerill, Garnett, 330 Cooper st., Camden (4)
 Summerill, John M., Pennsgrove (17)
 Summers, A. D., 180 Nassau st., Princeton (11)
 Summey, Thomas J., Moorestown (3)
 Surnamer, Isaac, 345 Broadway, Paterson (16)
 Surran, Carl A., Porf. Arts Bldg., Atlantic City (1)
 Sutherland, W. W., 320 Broadway, Paterson (16)
 Sutphen, E. Blair, 26 Maple av., Morristown (14)
 Sutter, Harry F., Pennsgrove (17)
 Sutton, Joseph G., Essex Co. Hosp., Cedar Grove (7)
 Swain, Richard D., 211 Roseville av., Newark (7)
 Swan, Guy H., Beachwood (15)
 Swayze, A. A., Hackensack (2)
 Sweeney, William J., 68 Clifton ter., Weehawken (9)
 Swern, Nathan, 130 W. State st., Trenton (11)
 Swift, Edw. M., 400 Division st., Perth Amboy (12)
 Swiney, Merrill A., 325 Ave. C, Bayonne (9)
 Symes, Earl H., 161 Kearny av., Kearny (7)
 Synnott, M. J., 63 S. Fullerton av., Montclair (7)
 Szerlip, L., 31 Lincoln Park, Newark (7)
 Thomas, Floyd A., Flemington (10)
 Thomas, George N., Vineland (6)
 Thomas, J. H., Jr., 270 Lenox av., S. Orange (7)
 Thomas, Mary L., State Vil. for Epil., Skillman (20)
 Thomas, Thomas S., 135 South st., Morristown (14)
 Thomas, W. B. S., 1 Park pl., Bloomfield (7)
 Thompson, Arthur F., 157 Harrison st., E. Or. (7)
 Thompson, Austin B., 479 Highland av., Orange (7)
 Thompson, C. S., Fair Oakes Sanat'm Summit (7)
 Thompson, P. H., 4612 Westfield av., Camden (4)
 Thomson, T. F., Lakewood (15)
 Thorne, Nathan, Moorestown (3)
 Thorne, Wm. P., 30 Main st., Butler (16)
 Thum, Ernest, 819 Ave. C, Bayonne (9)
 Tidaback, J. D., 447 Springfield av., Summit (20)
 Tidwell, H. F., 229 16th st., W. New York (9)
 Tildon, John W., 54 N. Clinton st., E. Orange (7)
 Timberlake, B. H., 1616 Pac. av., Atlantic City (1)
 Timlin, James W., 64 Beech st., Arlington (9)
 Tirrell, C. M., 36 Spruce st., Newark (7)
 Titman, Russell E., 275 Dodge st., E. Orange (7)
 Toal, Joseph, Ridgefield (2)
 Tobey, F. J., 11 Hazelwood av., Newark (7)
 Tobin, Adolph, Lakewood (15)
 Todd, Francis H., 83 Auburn st., Paterson (16)
 Tomassi, Chas. F., 173 Lafayette st., Newark (7)
 Tomec, Richard F., 55 S. Park st., Montclair (7)
 Tomlin, H. Hulbert, Wildwood (5)
 Tompkins, William, Hohokus (16)
 Townsend, Mary E., 4 S. Clinton pl., Atl. City (1)
 Toy, Calvert R., 92 Bayard st., New Brunswick (12)
 Toye, John E., 590 Kearny av., Arlington (7)
 Tracy, George T., Beverly (3)
 Trainor, James H., 40 Johnson av., Newark (7)
 Traverso, Daniel, 705 D st., Belmar (13)
 Treiber, Benj. A., 626 Perry st., Trenton (11)
 Trehella, Arthur P., 809 Mont'ry st., Jer. City (9)
 Trippe, C. M., 702 Asbury av., Asbury Park (13)
 Troedson, Bror S., Mendham (14)
 Trossbach, Herman, Bogota (2)
 Truax, Alfred J., Boonton (16)
 Tuers, George E., 418 Park av., Paterson (16)
 Tunison, G. O., Oxford (21)
 Turi, A., 57 Garside st., Newark (7)
 Turner, C. F., Grove & Cambr. sts., Montclair (9)
 Turner, I. F. P., 224 W. State st., Trenton (11)
 Turner, Wm. F., 519 Magie st., Elizabeth (20)
 Tutchulte, E., 111 Mt. Pleasant av., Newark (7)
 Tweddel, Geo. K., 239 Broadway, Paterson (16)
 Twitchell, A. B., 162 S. Orange av., S. Orange (7)
 Tymeson, Walter R., 310 Mani st., Orange (7)
 Tyndall, H. H., 83 Highwood ter., Weehawken (9)
 Tyrrell, Geo. W., 380 State st., Perth Amboy (12)
 Tyson, Francis B., Leonia (2)

ASSOCIATE MEMBERS

- Sacco, Gregory A., 440 N. York av., Union City (9)
 Sandler, Samuel, Trust Co. Bldg., Jersey City (9)
 Sasso, Albert, 99 Parker st., Newark (7)
 Sax, Max T., 84 Grove st., Bloomfield (7)
 Sheehan, Daniel C., 773 Sanford av., Newark (7)
 Singer, Sina S., 1969 Boulevard, Jersey City (9)
 Sisson, Nelson W., 144 Harrison st., E. Orange (7)
 Stage, Earl, 601 Clinton av., Newark (7)
 Stein, William, 71 Livingston av., N. Brunswick (12)
 Stiles, Clarence C., 114 N. 19th st., E. Orange (7)
 Stoddard, Gordon V., 41 S. Munn av., E. Orange (7)
 Taber, F. H., 3 Elm Row, New Brunswick (12)
 Taber, L., 266 Van Houten st., Paterson (16)
 Talbot, Herbert S., 144 Harrison st., E. Orange (7)
 Tansey, Wm. A., 520 Sanford av., Newark (7)
 Tarbell, Harold, 11 Pennington st., Newark (7)
 Tataryan, H., 422 New York av., Union City (9)
 Taylor, E. H., Franklin (19)
 Taylor, Herbert G., 590 Ridge av., Maplewood (7)
 Taylor, Walt. A., 450 Rutherford av., Trenton (11)
 Teeter, Charles E., 418 Orange st., Newark (7)
 Teeter, John N., Englewood (2)
 Telmer, Theodore, 17 Hillside av., Newark (7)
 Teller, D. W., Morristown (14)
 Tellman, D. H., 120 Lexington av., Passaic (16)
 Temes, J. Howard, 293 Ege av., Jersey City (9)
 Temple, Arthur H., 164 Jefferson st., Passaic (16)
 Tenney, A. S., 164 Harrison st., E. Orange (7)
 Tennis, E. N., Tenafty (2)
 Terhune, P. H., 171 Paulson av., Passaic (16)
 Terriberry, W. K., Room 800, 26 Bigaw, New Y'k (7)
 Teskey, Stanley, 10 Anderson rd., Bernardsville (14)
 Tether, Russell K., Cloiser (2)
 Thalheimer, E. J., Vineland (6)
 Thomas, Floyd A., Flemington (10)
 Thomas, George N., Vineland (6)
 Thomas, J. H., Jr., 270 Lenox av., S. Orange (7)
 Thomas, Mary L., State Vil. for Epil., Skillman (20)
 Thomas, Thomas S., 135 South st., Morristown (14)
 Thomas, W. B. S., 1 Park pl., Bloomfield (7)
 Thompson, Arthur F., 157 Harrison st., E. Or. (7)
 Thompson, Austin B., 479 Highland av., Orange (7)
 Thompson, C. S., Fair Oakes Sanat'm Summit (7)
 Thompson, P. H., 4612 Westfield av., Camden (4)
 Thomson, T. F., Lakewood (15)
 Thorne, Nathan, Moorestown (3)
 Thorne, Wm. P., 30 Main st., Butler (16)
 Thum, Ernest, 819 Ave. C, Bayonne (9)
 Tidaback, J. D., 447 Springfield av., Summit (20)
 Tidwell, H. F., 229 16th st., W. New York (9)
 Tildon, John W., 54 N. Clinton st., E. Orange (7)
 Timberlake, B. H., 1616 Pac. av., Atlantic City (1)
 Timlin, James W., 64 Beech st., Arlington (9)
 Tirrell, C. M., 36 Spruce st., Newark (7)
 Titman, Russell E., 275 Dodge st., E. Orange (7)
 Toal, Joseph, Ridgefield (2)
 Tobey, F. J., 11 Hazelwood av., Newark (7)
 Tobin, Adolph, Lakewood (15)
 Todd, Francis H., 83 Auburn st., Paterson (16)
 Tomassi, Chas. F., 173 Lafayette st., Newark (7)
 Tomec, Richard F., 55 S. Park st., Montclair (7)
 Tomlin, H. Hulbert, Wildwood (5)
 Tompkins, William, Hohokus (16)
 Townsend, Mary E., 4 S. Clinton pl., Atl. City (1)
 Toy, Calvert R., 92 Bayard st., New Brunswick (12)
 Toye, John E., 590 Kearny av., Arlington (7)
 Tracy, George T., Beverly (3)
 Trainor, James H., 40 Johnson av., Newark (7)
 Traverso, Daniel, 705 D st., Belmar (13)
 Treiber, Benj. A., 626 Perry st., Trenton (11)
 Trehella, Arthur P., 809 Mont'ry st., Jer. City (9)
 Trippe, C. M., 702 Asbury av., Asbury Park (13)
 Troedson, Bror S., Mendham (14)
 Trossbach, Herman, Bogota (2)
 Truax, Alfred J., Boonton (16)
 Tuers, George E., 418 Park av., Paterson (16)
 Tunison, G. O., Oxford (21)
 Turi, A., 57 Garside st., Newark (7)
 Turner, C. F., Grove & Cambr. sts., Montclair (9)
 Turner, I. F. P., 224 W. State st., Trenton (11)
 Turner, Wm. F., 519 Magie st., Elizabeth (20)
 Tutchulte, E., 111 Mt. Pleasant av., Newark (7)
 Tweddel, Geo. K., 239 Broadway, Paterson (16)
 Twitchell, A. B., 162 S. Orange av., S. Orange (7)
 Tymeson, Walter R., 310 Mani st., Orange (7)
 Tyndall, H. H., 83 Highwood ter., Weehawken (9)
 Tyrrell, Geo. W., 380 State st., Perth Amboy (12)
 Tyson, Francis B., Leonia (2)
 Ulan, Oscar, 170 Fleming av., Newark (7)
 Ulmer, Chester I., Gibbstown (8)
 Ulmer, David H. B., Moorestown (3)
 Underwood, J. Harris, Woodbury (8)
 Undinsky, Hyman J., 29 Passaic av., Passaic (16)
 Upham, Helen T., 305 3d av., Asbury Park (13)
 Uptigrove, E. P., Vernon (19)
 Urbanski, Adrian X., 148 Market st., P. Amboy (12)
 Urbanski, Ardia X., 148 Mkt. st., Perth A'boy (12)
 Urevitz, A., 495 New York av., Union City (9)
 Uzzell, Edw. F., 2703 Pacific av., Atlantic City (1)
 Vaczi, Stephen, 983 S. Broad st., Trenton (11)
 Vail, Herbert B., 301 Washington av., Belleville (7)
 Vail, James Lindley, 28 Holly st., Cranford (20)
 Vail, William Penn, Blairstown (21)
 Vanderbeek, Andrew B., 174 B'way, Paterson (16)

ASSOCIATE MEMBER

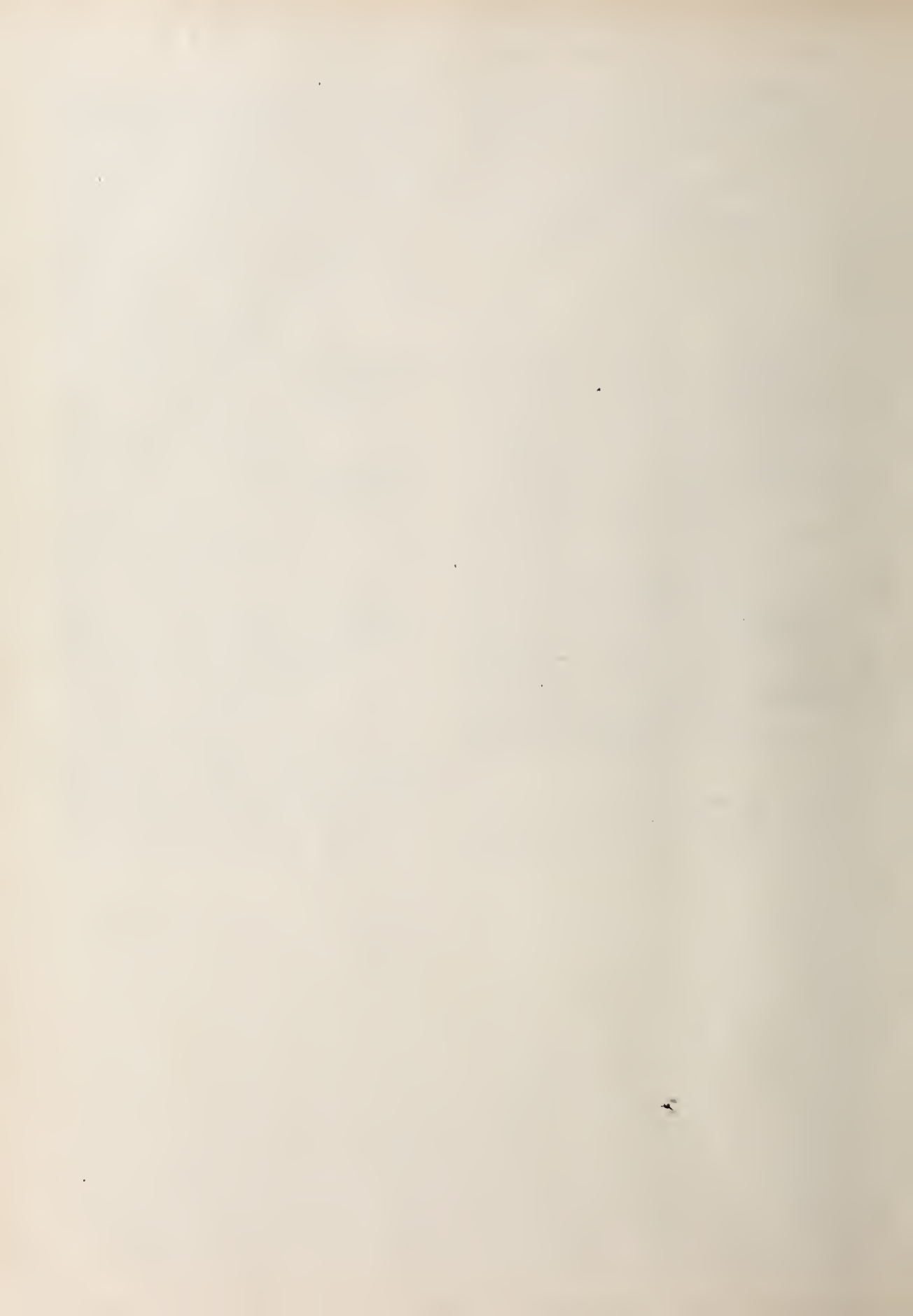
- Taft, Herman L., 25 Liberty pl., Weehawken (9)
 Thum, K. W., 354 Main st., W. Orange (7)
 Tillis, Herman H., 11 Bergen st., Newark (7)
 Ulan, Oscar, 170 Fleming av., Newark (7)
 Ulmer, Chester I., Gibbstown (8)
 Ulmer, David H. B., Moorestown (3)
 Underwood, J. Harris, Woodbury (8)
 Undinsky, Hyman J., 29 Passaic av., Passaic (16)
 Upham, Helen T., 305 3d av., Asbury Park (13)
 Uptigrove, E. P., Vernon (19)
 Urbanski, Adrian X., 148 Market st., P. Amboy (12)
 Urbanski, Ardia X., 148 Mkt. st., Perth A'boy (12)
 Urevitz, A., 495 New York av., Union City (9)
 Uzzell, Edw. F., 2703 Pacific av., Atlantic City (1)
 Vaczi, Stephen, 983 S. Broad st., Trenton (11)
 Vail, Herbert B., 301 Washington av., Belleville (7)
 Vail, James Lindley, 28 Holly st., Cranford (20)
 Vail, William Penn, Blairstown (21)
 Vanderbeek, Andrew B., 174 B'way, Paterson (16)

- Vanderbeek, S. W., Englewood (2)
 Vander Clock, C., 23 Passaic av., Passaic (16)
 Vanderhoff, I. M., 9 Clinton st., Newark (7)
 Vandersluis, H., Park Ridge (2)
 Van Der Veer, H. G., 295 Montg'ry st., Bl'm'f'd (7)
 Van Deusen, Edwin H., Vineland (6)
 Van Dyke, Joseph S., Palisade Park (2)
 Van Dyke, Benjamin S., Cranbury (12)
 Van Emburg, G. H., 575 Belgrove dr., Arlington (7)
 Van Erde, A. H., 339 Lafayette av., Hawthorne (16)
 Van Geison, Edward J., 17 Park pl., Bloomfield (7)
 Van Horn, A. F., 514 Central av., Plainfield (20)
 Vannatta, Geo. W., 224 N. Park st., E. Orange (7)
 Vanneman, Joseph S., 180 Nassau st., Princ't'n (11)
 Van Ness, H. R., 444 Parker st., Newark (7)
 Van Neste, George V., Hopewell (11)
 Van Riper, A. Ward, 605 Main av., Passaic (16)
 Van Schott, Gerald J., Jr., 245 Lex. av., Pass'c (16)
 Van Sciver, John E. L., 106 B'way, Camden (4)
 Van Urk, F. T., 149 Lexington av., Passaic (16)
 Van Winkle, J. S., 297 Broadway, Paterson (16)
 Varney, W. H., Washington (21)
 Varriano, John L., 3258 Blvd., Jersey City (9)
 Verbeck, Geo. B., 26 Wushburn pl., Caldwell (7)
 Villapiano, Jos. G., 706 Mattison av., Asbury P'k (13)
 Vinciguerra, Michael, 410 Westm'ster av., Eliz. (20)
 Visconti, Jos. A., 711 Garden st., Hoboken (9)
 Vitale, Dominick, 681 Newark av., Elizabeth (20)
 Viteri, Louis, Mt. Holly (3)
 Vogel, H. A., 1060 E. Jersey st., Elizabeth (20)
 von Deeston, H. T., 268 Palisade av., Jersey City (9)
 Von Hofe, F. H., 255 Conway Ct., E. Orange (7)
 Von Oehsen, W. H., 409 5th av., Broadlay Be'h (13)
 Voorhees, Florence E., 83 Lincoln Park, Newark (7)
 Voorhees, H. C., 43 Bayard st., New Brunsw'k (12)
 Voorhees, Lamar, Newton (19)
 Voorhies, W. S., Mendham (14)
 Vosburg, Fred, 125 Prospect st., Passaic (16)
 Vostrosablin, N. A., 121 Grand st., Jersey City (9)
 Vreeland, Hamilton, 232 S. Irving st., Ridgew'd (9)
 Vreeland, Ralph J., 266 Van Houten st., Pat'son (16)
 Vreeland, R. D., 333 Lyons av., Newark (7)
 Vreeland, Wm. N., 32 Bergen av., Jersey City (9)
 Vroom, W. L., Ridgewood (2)

ASSOCIATE MEMBERS

- Van Duzer, Reeves B., 226 N. Park st., E. Or'ge (7)
 Varmus, Frank, 389 Leslie st., Newark (7)
- Wacker, William F., 42 Hollywood av., Hillside (20)
 Wade, S. F., 555 Newark av., Elizabeth (20)
 Wagner, J. G., Riverside (3)
 Wagner, Otto, 111 Stiles av., Elizabeth (20)
 Wainwright, F. P., Bridgeton (6)
 Wakeley, Wm. A., 120 Main st., Orange (7)
 Wakeley, W. E., 521 Main st., E. Orange (7)
 Walker, Ada Harris, Vineland (6)
 Walker, H. Burton, Vineland (6)
 Walker, Harold G., Everett av., Wyckoff (16)
 Walker, Levi M., 151 Penn av., Atlantic City (1)
 Walker, R. B., 108 Church st., New Brunswick (12)
 Wallach, B., North Plainfield (18)
 Wallhauser, H. J. F., 31 Lincoln Park, Newark (7)
 Wallin, Alfred C., 195 Main st., Matawan (13)
 Walsh, Ronald J., 328 Chestnut st., Roselle (20)
 Walsh, T. M., Hasbrouck Heights (2)
 Walsh, Thos. J., 335 S. Broad st., Elizabeth (20)
 Walsh, Thomas J., 1158 E. State st., Trenton (11)
 Walton, Gordon G., 17 Church st., Paterson (16)
 Walton, R. W., 48 N. Fullerton av., Montclair (7)
 Wambaganss, M., 44 Devine st., Newark (7)
 Warburton, Jack C., 71 Ward st., Paterson (16)
 Ward, Alfred W., Demarest (2)
 Ward, G. Harold, Englewood (2)
 Ward, Gertrude P., 41 Park pl., Bloomfield (7)
 Ward, John V., 438 Palisade av., Weehawken (9)
 Ward, Leo J., 137 W. Jersey st., Elizabeth (20)
- Ward, Sethe A., 325 Cooper st., Camden (4)
 Ward, Wm. R., 112 Chancellor av., Newark (7)
 Ware, Carl N., Shiloh (6)
 Ware, Francis V., Millville (6)
 Warncke, F. H., 523 Westfield av., Elizabeth (20)
 Warner, W. H. A., 444 Central av., E. Orange (7)
 Warren, Charles B., Bergenfield (2)
 Warren, D. E., 265 Gregory av., Passaic (16)
 Warren, Jacob, 372 E. 35th st., Paterson (16)
 Warter, P. J., 626 W. State st., Trenton (11)
 Washburn, Philip C., Greystone Park (14)
 Wassing, Hans, 695 Broadway, Paterson (16)
 Waters, C. H., 928 W. State st., Trenton (11)
 Waters, Edw. G., 39 Gifford av., Jersey City (9)
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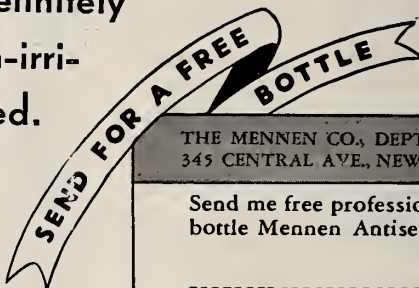


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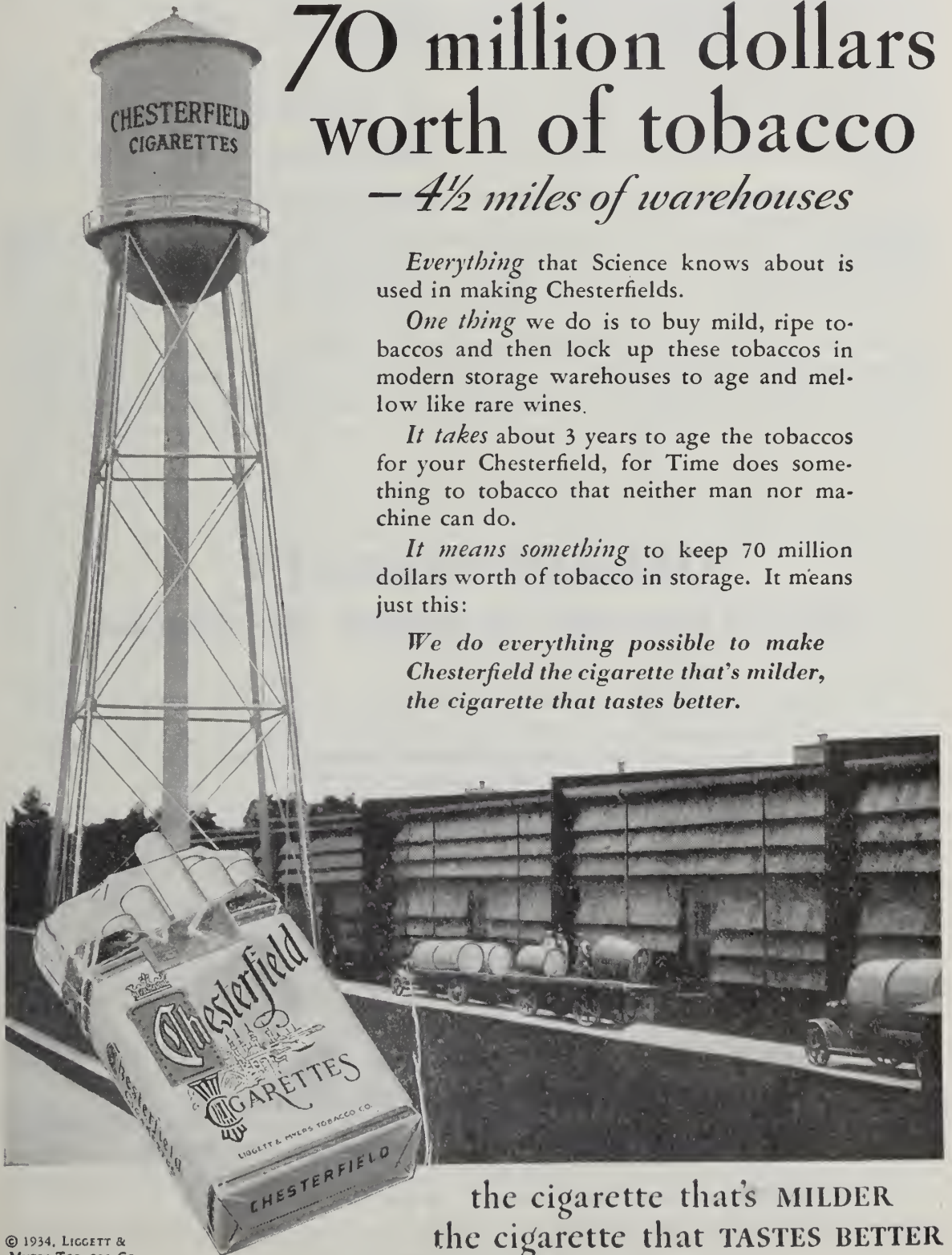
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In diarrhea, "The sugar is added gradually, conditions admit, some sugar other than milk sugar or cane sugar being used, preferably dextrin and maltose."—H. E. Small: *Diarrhoea in bottle-feeding*, J. Moine M. A. 12:152-158, Jan. 1932.

In diarrhea, "Carbohydrates, in the form of dextri-maltose, well cooked cereals or rice, usually can be handled without trouble."—B. B. Jones: A discussion of some of the commoner types of infantile diarrhea, and the principles of the diets used in their treatment. *Monthly*, 66: 411-412.

"The most desirable sugar is dextrin-maltose because of all the sugars maltose is least apt to ferment."—A. I. Blau: *The use of protein milk* p. 119-120, April 2, 1907.

Concerning the treatment of weight remains stationary, it is an indication that loss of substance is occurring through the stools, most in the form of alkaline salts. To equalize this loss of substance, the diet must be increased, in such a way as to avoid causing fermentations. This may be done by adding dextrin-maltose and preparations of protein to the food, increasing the calories until the infant is taking 160 calories per kilo. of body weight. —H. L. Kainoff
Nutritional disturbances, Arch. Pediat., 4:771
Nov., 1924.

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are intelligently prescribed. By mallose. What
proper proportions to looseness. I have used it
there is a tendency to looseness. I have used it
hydrates. . . . M. Ladd: Further
After the preliminary short period of starva-
tion, protein milk should be used. . . . When the
mallose may be added sufficiently cheap. . . .
until the child is well." M. Ladd: Further

—W. L. Denney: Acute nutritional disturbances of infancy. Univ. West. Ontario M. J. 2:132-137, April, 1932.

Regarding the treatment of diarrhea, "In our experience, the most satisfactory carbohydrate for routine use is Mead's dextrimaltose No. 1." —F. R. Taylor: "Summer Complaints," *Southern Med. & Surg.*, pp. 555-559, August, 1927.

In cases of diarrhea, "For the first day or so no sugar should be added to the milk. If the bowel movements improve carbohydrates may be added. This should be the one that is most easily assimilated, so dextri-maltose is the carbohydrate of choice."—*W. H. McCaslan: Summer diarrheas of infants and young children, J. M. A. Alobama. 1:278-282, Jan., 1932.*

"It is desired to feed an unusually large amount of sugar to a baby, it is well to use maltose-sugar preparation, as in this way there is less danger of bringing about sugar fermentation than if lactose were used."—*L. W. H. Phila., 1922, p. 206.*

"The young baby usually one-third milk and two-thirds formula, usually skimmed at first, and a half oatmeal. We prefer Dextro-Maltose. Preparations containing maltose are most easily digested. Lactose is absorbed, but the more maltose are more rapidly absorbed, and the more maltose are more liable to produce diarrhea. . . . Lactose which was very popular some time, is never used in our work. The consensus of opinion seems to be that milk sugar is often the source of indigestion in normal infants and in primary causes of fermentative dyspepsias."—*Experiences*, of J. H. Reading, Jr., *Arch. Pediatr.*, 1923, 10, 193.

Protein milk may be continued for several weeks when a gradual transition to a whole milk evaporated milk formula, which will supply all the protein and calories needed, is made. When the baby has gained one and one-half to two ounces of whole milk for every pound of body weight, is reached. This amounting to five to seven per cent. —K. Strong: Summer diarrheas in infancy and childhood, Arch. Pediat. 47:344-354, June, 1930.

diarrhea. "Dextri-maltose
for, they do not ferment
orbed and leave very little
A. Blenk: Protein milk
Pediat., 42:743-760, Nov.,

rest to partly lactose by de-
mixtures (Mead's Nos. 1 and 2). In our view can-
sugar is less suitable than lactose, and if for any
reason there is objection to the use of lactose,
is obtained by the addition of carbohydrates, while
fat and casein are reduced. For this purpose de-
trimaltese and flour are better than the ordinary
sugars, since they are more slowly absorbed and
have greater efficacy in the system."—W. J. Pearse
the flora in the large intestine."—
"W. G. Willsie, Agent Advancing in Disease"
The Kingston's Son & Co., Phila., 190

For cases of fermentative diarrhea, "... ideal plan of treatment would be to give a food which is low in sugar (the food which that group of organisms thrive on) and high in protein. Calcium caseinate milk accomplishes this purpose. In our series of cases, we found it was necessary to use the casein calcium for from 5-8 days; we then stopped it and added dextro-maltose to the formula. —A. G. DeSouza and L. L. Pender: The value of calcium caseinate milk in fermentative diarrhea, Arch. Pediat., 1924, 41, 107-110.

Just as DEXTRI-MALTOSE is a carbohydrate modifier of choice, so is CASEC (calcium caseinate) an accepted protein modifier. Casec is of special value during the smm-

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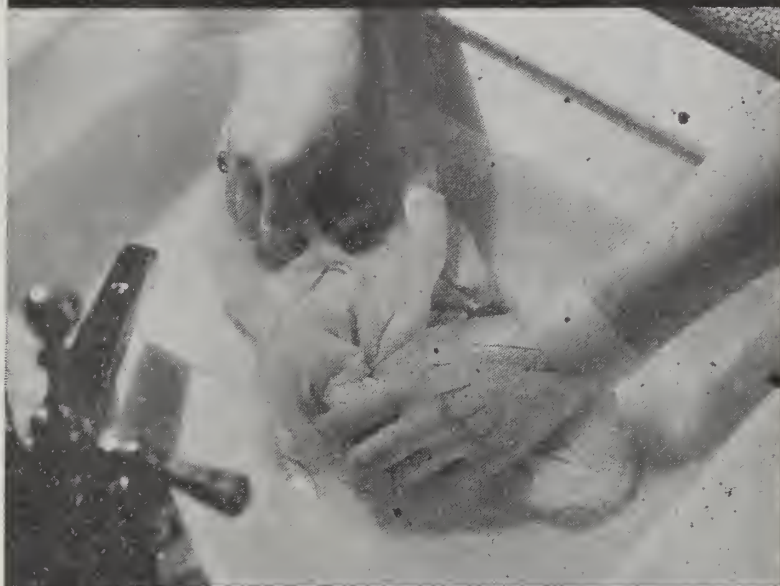
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The February issue of Colorado Medicine has the following editorial comment on fraudulent certificates of health:

"In Colorado such public servants as barbers, cosmetologists, and food handlers are supposed to have a clean bill of health. They hold a card signed annually by doctors of medicine who state that they are free from tuberculosis, venereal, or other communicable disease. Many shops prominently display a card stating that their employees have conformed with the 'sanitary code' and are safe as public servants. And the public believes it!

"Tragic also is the fact that doctors of medicine have placed their names on the vehicles of this

misrepresentation. Those 'certificates' are not only meaningless but are public liabilities. We have known that for at least two years barber and beauty shops have been visited by an unscrupulous doctor who signs the slips for fifty cents each and without any examination. Food handlers have gotten a certificate designating a clean bill of health for seventy-five cents apiece. The latter was obtained from a physician belonging to organized medicine.

"The plan is obviously supervised by laymen who are either ignorant of scientific facts or are disregarding public health for personal gain. Physicians who have subscribed to the misrepresentation are guilty of an act unbecoming to their profession."

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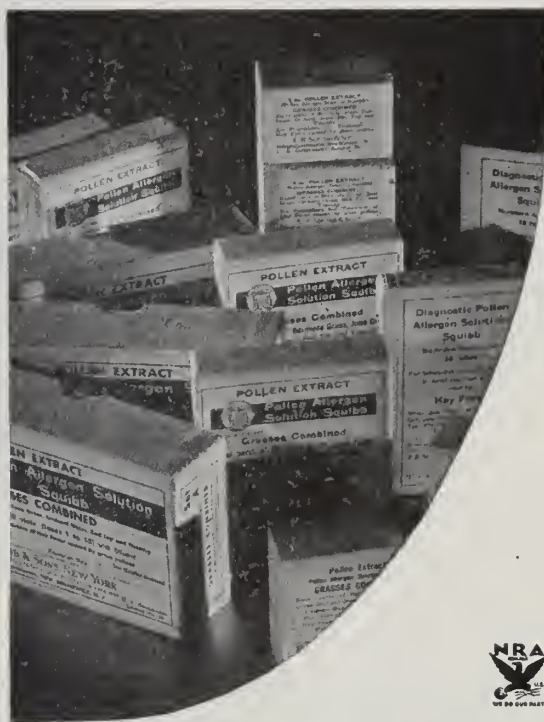
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



EDITOR OF
THE JOURNAL
FRANK OVERTON, M.D., Dr. P.H.

OFFICES OF THE SOCIETY—137 EAST STATE STREET, TRENTON, N. J., TEL. 9330
EXECUTIVE SECRETARY—LEROY A. WILKES, M.D.

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Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.
Officers, Trustees, Councilors and Committees of the Society are listed on page xxii of the Advertising Section.

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MAY, 1934

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EDITORIALS

The Annual Reports

The distinguishing feature of this, the May number of *The Journal* is that it is a studied preparation for the annual meeting of The Medical Society of New Jersey, which will be held on June 5, 6 and 7, 1934, in Atlantic City. It contains the *Annual Reports* of the officers and committees which pre-empt the space of the department of "Original Articles". But these reports are valuable contributions to the art and science of medical practice; for they are "clinical" reports of actual experiences in the field of the practice of medicine by *medical societies* in distinction from that by individuals. Physicians will have a special interest in this department, for the members of the State Society are the patients whom the officers have examined and found to be developing normally in their relations to one another and the public.

These reports have been prepared after special study, and careful attention to essential details. They place special emphasis on recommendations for future action. Three steps were taken in order to make the reports complete, accurate and informative, and to coördinate them with one another:—

- (1) A common plan
- (2) A review of each report
- (3) A final coördination.

PLAN OF REPORT

The following outline was given to each officer and chairman suggesting a plan for him to follow in developing his report:

"In order to facilitate and clarify the work of the House of Delegates, it is planned to publish the reports of the officers and committees in the May Journal. A standard report will contain information along three lines:—

"(1) A record and description of the items of the work that was done. It may be formal and statistical; or a description written in popular style.

"(2) A discussion of the principles underlying the activities. The report may be in the form of an essay; or a brief comparison of what was expected with what was actually accomplished.

"(3) Suggestions for future actions and policies to be considered by the delegates.

"It will help the officer or chairman to clarify and arrange his report and recommenda-

tions if he considers exactly whom he is addressing. He may give one of three answers:

"(1) The physicians of New Jersey.

"(2) The members of the House of Delegates.

"(3) The members of the Reference Committee of the House.

"If he addresses himself to the four or five members of the reference committee, he will be more concise and definite than he would be if he addresses himself to the 175 members of the House of Delegates, or the 2750 members of The Medical Society of New Jersey.

"A report will make the best impression if it is brief and contains definite suggestions for future action."

REVIEW OF REPORTS

While each report was written by an officer, or a chairman of a committee, yet each of the more important ones was reviewed by the entire committee. The reports of the Sub-Committees of the Welfare Committee, for example, were read before the entire membership of the Welfare Committee, and the suggestions of individual members were given consideration; but the conclusions and recommendations represent the unanimous opinion of the thirty-five members who compose the committee. The reports reflect the careful judgment of the leaders of the medical society so far as they can be expressed in a few paragraphs.

CO-ORDINATION

A final coördination of the reports was made by the informal action of the President in considering each report in relation to all the others, so as to make the collection a harmonious entity. Careful consideration was also given to the effect which a report might have on organizations and individuals outside of the medical profession, especially legislators and public officials. A special effort was made to eliminate grounds for ill-feeling and to emphasize *constructive* suggestions.

BASIS FOR ACTION

The recommendations contained in the annual reports will be the subjects for the greater part of the proceedings of the House of Delegates. The publication of the reports will

enable the delegates to study the projects of the State Medical Society, and to visualize the manner of their execution. The delegates will have the opportunity to express their approval or criticism before the time of the annual meeting; and thereby debates will be clarified, and the transaction of business hastened. Moreover, each delegate will understand what is going on, and will have an incentive to attend every session of the House.

Equally important with the annual reports will be the actions taken regarding them by the House of Delegates. These actions will be set forth in the "Transactions", which will be issued as soon as possible after the annual meeting—probably with the August number of The Journal.

FUTURE VALUE

The reports will reach their maximum value during the months immediately following the annual meeting; while the transactions of the House of Delegates will be carefully studied by the new officers in order to determine their duties and formulate their lines of action. But events become impersonal history within half a decade after their occurrence; their perspective is distorted, and their very existence often forgotten. The personnel of the officers and committeemen of medical societies change as each serves his brief term and relinquishes his official privileges and opportunities to a successor to whom his experiences and impressions are invaluable when they are made available in vivid reports.

It is a curious fact that suggestions for action by medical societies often come in cycles, and that the same propositions are put forth every five years as original discoveries by new leaders—who, in fact, deserve credit for their own originality. The medical historian performs essential duties when he reproduces the events of each year in tracing the development of a progressive movement and its repeated incarnations in successive groups of leaders.

It may be anticipated that future historians will find that the annual reports of the officers and committees of the Medical Society of New Jersey for 1934 are prominent landmarks on the Road to Progress, pointing the way to definite achievements.

Rating the State Society

The *Medical Record* of April 18 is a New Jersey number in which articles by the practitioners of the state fill 38 pages, 9 of which deal with methods of delivering medical services. The leading editorial states:

"The medical profession at large knows too little about the splendid work that is being done in this small state between the metropolitan districts of Philadelphia and New York—New Jersey need not apologize for the progress it has made in the field of medicine—We feel that we have done scant justice. . . . to the splendid work that has been done by progressive physicians, citizens, and executives of the State of New Jersey."

The physicians of New Jersey are modest. They are so much engaged in developing their own resources and systems of service, and are so uncritical of conditions in other states that they are perhaps unaware of the degree of the efficiency of their own organizations. It will therefore be well to review some of the major conditions which have contributed to the high standing of the Medical Society of New Jersey, and of its 21 component county societies.

GEOGRAPHIC

New Jersey has an area of nearly 8000 square miles, and a population of 4,000,000 persons, who are served by 4000 active physicians, of whom 2750 are now members of its state medical society. It stands tenth among the states of the Union in the number of physicians, and of members of the state society. Its system of railroads and of concrete highways promote easy communication, and any physician can attend a meeting of a society or committee in an afternoon and return on the same day.

The physicians of New Jersey feel the medical influence of New York and Philadelphia, and still are not dominated by it; but on the contrary the contributions of the larger medical centers of New Jersey are equal in quality to those of the metropolitan cities.

Ease of communication and the inspiration of two great cities on her borders, are important elements in the adoption of an advanced system of medical service in New Jersey.

ORGANIZATION

The plan of organization of the Medical Society of New Jersey may be characterized as one of *decentralization* in that its work is done through committees, about twenty in number; yet the responsibilities and duties of the committees are coördinated effectively in the President and his staff of elected officers.

The system is flexible and is well adapted to new situations as they arise.

A distinguishing feature of the organization of the State Society is its *Welfare Committee*, consisting of 35 members, some especially elected, and some ex-officio. This committee acts principally through its sub-committees, which are appointed for special duties as occasions may arise. But the entire committee holds frequent meetings, which are attended by fully ninety per cent of its members. Each sub-committee therefore has the support of the entire committee.

The list of the officers and committeemen of the state society that is published in each issue of *The Journal* contains the names of 150 members. To this list can be added the names of the county society officers that are directly concerned with the activities of the state society. The physicians who officially administer the affairs of the state society therefore number over 200, or one in every 15 members. If the active members of the committees of the county societies are also considered, ten or fifteen per cent of the members of the state society are formally enrolled as official workers.

DEMOCRACY OF ADMINISTRATION

The large number of officers and committeemen engaged in state society activities produces a *democracy of administration*, and promotes the participation of every county society, and the active interest of every individual member in the equitable distribution of medical services. The state society may be properly characterized as a *democracy at work*.

DEFINITENESS OF OBJECTIVES

One source of efficiency in the work of The Medical Society of New Jersey is the adoption of definite projects for promotion throughout

the state. The two which were adopted for the present year were the Emergency Relief Administration, and Diphtheria Immunization. Both of these projects were presented to each county society, together with a definite plan of action. But each society was left free to do its work by its own methods, provided its standards of efficiency were equal to those of the state society. The adoption of a uniform plan of action has been of great encouragement to the local societies in the development of their own local work.

LEGISLATION

The Medical Society of New Jersey has demonstrated its influence upon the Legislature. It has exerted that influence informally in two ways:

(1) The official contact of its Executive Secretary with the Legislators.

(2) The close association of physicians with their individual lawmakers.

The custom of the legislature to hold sessions on only one or two days in each week has enabled the local physicians to call on their legislators and explain the attitude of the medical profession in regard to health laws. The demonstration of interest in bills by local physicians has been a great factor in securing the passage of measures for the benefit of the medical profession and the cause of public health.

LAY HEALTH ORGANIZATIONS

Physicians entering public health work in New Jersey have found themselves practically alone, with no large group of laymen dominating the field. They have therefore been able to develop their own programs of community action along practical lines and to assume their natural leadership in evolving standards of health services, such as diphtheria immunization, and the medical care of the poor. Yet they have realized the essential need of the assistance of those groups of citizens who influence public opinion in the matter of health. The Medical Profession of New Jersey has assumed the position of senior member in a partnership which includes public officials and lay health organizations. They are demonstrating their leadership in all lines of administration of medical services. Their policy is to work *with* rather than *for* governmental agencies and public health organizations.

OPPORTUNITIES

Medical service, like all other forms of human endeavor, depends for its success on the two factors of *abilities* and *opportunities*. The physicians of New Jersey are exactly the same as those of the other states in their abilities and their preparation for practice. They have certain advantages of opportunities and of freedom from obstacles, but the essential factors in their achievement of a high rating are their ability to recognize opportunities, and their readiness to adapt themselves to new relations.

Medical History in the Making

The physicians of New Jersey are rapidly making medical history. The events at a county medical society meeting are unrelated *episodes* on the day of the meeting.

They become *current events* when they appear in orderly rank and dress on a page of the *State Journal*.

They develop into *medical history* within a year as the officers analyze the items of progress and achievement in their annual reports, and dignify them with recommendations for their continuance and extension.

They achieve distinction as *landmarks of progress* within half a decade, when the societies are served by a new generation of leaders who look to their predecessors for guidance and inspiration.

The making of medical history begins in every county society meeting; and its writing is easy when the society does something that is worthy of record. The value and influence of the activities of county societies are revealed in the department of county society news, which is a feature of the journals of

most state medical societies. A few years ago a typical report of a county society meeting consisted of its scientific program only. The report of practically every meeting of every county society in New Jersey now contains several paragraphs of discussions of the civic duties of physicians, and their relation to activities of an economic and welfare nature. Every county society in New Jersey has a *reporter*, who finds an abundance of items to report because the societies are active.

Items of county society news do not attain to the dignity of medical history unless they are indexed according to subjects that are discussed and described. It is the sum of the attitudes of county societies that make up the policy of the state society. A full index of the county society activities reported in this Journal may be expected at the end of the year, when every reporter may see the evidence of appreciation of his work.

The Pediatrician in Public Health

Medical and Lay Workers—There are two main types of organizations engaged in public health activities. One group comprises the medical societies and the public health departments of the Nation, State, County, City, or other community. These organizations were founded primarily for the delivery of health services through the practice of scientific medicine.

The other group of public health workers consists predominantly of non-medical workers and includes educators and social workers both professional and lay. The health implications and contacts of this group are so numerous that, although the organizations were founded for purposes other than health, they have themselves endeavored to provide these health services as a regular part of their work, especially along preventive lines and with children. Their main excuse of engaging in the practice of preventive medicine was that physicians were not active in cultivating that particular field. Those pioneer doctors who had entered it had found no standard methods of conducting this work and no organizations to provide the means by which the doctors might deliver their services to the needy, or the sick make use of them. On the other hand, when laymen entered the field of the practice of medicine, they attempted too much and asked the doctors to do things impossible to accomplish. The practicality of the family doctor ran against the idealism of the social worker, and there were head-on collisions and blockades on the road of progress.

The Field of Child Hygiene—The pediatrician was the first practitioner to enter the field

of preventive medicine. Beginning in his own private practice by educating the parents of his patients regarding the benefits of the prevention of sickness, he expanded his contacts so as to include various types of community activities such as the immunization clinic, the health examination of school children, the summer round-up, and the health activities of the parent-teachers association. His demonstrations led to the adoption of child hygiene as a field in which the doctor and the social worker could labor together for a common purpose. The crop to be raised was healthy children. The cultivators of the field consisted of three groups of workers:

- (1) The doctors who formulated the plans for nurturing and protecting the growing child.

- (2) The mothers who were anxious that their children should grow up in good health physically, mentally, and morally.

- (3) The social workers who advised and assisted the mothers in carrying out the plans and rules laid down by the doctors.

The physician marked out the field of each worker, and prescribed the order and manner of its care; the mother nurtured the growing child and gave it her tender oversight; while the social worker provided the mother with the tools for her work and the knowledge and sympathy to inspire her during her weary hours of labor. There was plenty for each group to do. They all worked in harmony to grow a beautiful flower of childhood which should develop into the perfect fruit of youth and manhood.

The success and popularity of the new field of practice resulted in the adoption of *child hygiene* as a bureau in official departments of health—the first bureau to be added to the original triad of sanitation, communicable diseases, and vital statistics. It was the universal appeal of the little child that roused the community to provide the means by which the doctor could heal the helpless sick and the welfare worker to feed the hungry and clothe the naked.

Soliciting Patients in Preventive Medicine—The pediatrician also showed his medical brethren how they could profit by fostering the new field of preventive medicine. Child specialists demonstrated the sound ethics of the plan that the doctor should remind the mother of his baby patient that now is the time to bring the child to him for immunization, dietary advice, and a check-up of its growth and physical condition.

The response of the general practitioner to the plans of the pediatrician has been gratifying to such an extent that the Medical Society of New Jersey had adopted diphtheria immunization as a major objective during the present year, and is laying its plans along two lines:

- (1) Publicity, in order to remind the people to bring their children to the doctor's office for immunization.

- (2) The delivery of the immunization by the family doctor.

It is the expectation of the committee that the burden of publicity and education shall be assumed by lay health organizations, such as parent-teachers associations; and that the immunizations shall be given by family physicians in their offices.

Economics—The willingness of the people to pay for a medical service is a test of its popularity and of the value which citizens place upon it. Medical societies are expected to develop agreements with the welfare officials and social agents by which the lay workers shall secure the attendance of parents and children upon their family doctor. These arrangements must include the economics of the relations of family doctors to the other groups which are interested in the delivery of preventive services. The physician deserves a fee

which will reimburse him for his own financial outlay in excess of that which every citizen owes to his community.

Few people realize the expense which the doctor incurs when he treats the poor. A non-paying case imposes an actual outlay upon the doctor for office rent, automobile transportation, and other expenses connected with the delivery of his service. While the doctor is willing to make a donation of his professional service, yet his personal expense in treating the poor is a proper charge upon the community.

Public Relations—The county medical society is the mutual agent of both the physicians and the lay agencies which are concerned with the delivery of medical services. The Committee on Public Health of the State Society has formulated the principles of the service of diphtheria immunization; the county societies must work out the application of those agreements in each local community. The earnestness and sincerity with which each county society, rural or urban, works out the problem of diphtheria immunization within its own area, will have great effect in determining the method of medical practice in future years.

Problems of Adult Life—Every family doctor is a practitioner of pediatrics, and is deeply interested in all phases of the service of child hygiene. But he is also interested in the health problems of adult life, such as tuberculosis, maternal mortality, venereal disease control, and cardio-vascular conditions; and will be ready to assume their control along the lines that are evolved by experience in the diphtheria immunization campaign of the Medical Society of New Jersey.

State medicine is often advocated in the belief that the medical profession itself cannot organize and conduct a medical service suited to the needs and customs of the people, unless some lay agency plans and directs the system of its delivery. There is the opportunity for the Medical Society of New Jersey to demonstrate that its practicing physicians can, and will, provide such a medical service economically and satisfactorily.

LE ROY A. WILKES,
Executive Secretary.

THE MEDICAL SOCIETY OF NEW JERSEY ANNUAL REPORTS

of the
OFFICERS AND COMMITTEES
June 7, 1933, to June 5, 1934

REPORT OF THE PRESIDENT

By FREDERIC J. QUIGLEY, M.D.

To the House of Delegates:

In an address to the Welfare Committee October 15, 1933, as President, I outlined a policy and program which represented my judgment as to the activities which should be pursued by the Society during my administration. This program was endorsed by the President-Elect, Dr. Ely, and the First and Second Vice-Presidents, Drs. Newcomb and Haussling. (Journal, Nov. 1933, page 751.)

The Welfare Committee being composed of 35 members, with at least one member from each Component Society, and charged with the responsibility of "supervision over legislative matters, public health and public relations" and with "all questions of professional welfare not included in the specific work of the Judicial Council", it seemed highly desirable and necessary that this committee inaugurate its work by a clear statement of its purposes.

A summary of the objectives proposed and adopted is as follows:

Through the *Public Health Committee*: To coördinate all medical activities in the various counties under the supervision of the county medical societies; and to recapture and return to the doctor the rapidly enlarging field of Preventive Medicine.

Through the *Committee on Hospitals and Medical Education*: To establish a sound staff relationship to hospitals, and a sound policy as to free care of patients in hospitals and clinics; and to eliminate unfair competition by hospitals and clinics.

Through the Welfare Committee:

1. Improvement in operation of the Workmen's Compensation Act; and, if necessary, amending the Act to provide for freer choice of physicians.

2. Amendment to the present "Hospital Lien Law" to include liens covering physicians' fees in liability cases.

3. Legislation providing a single standard for licensure and limiting the use of the title "Doctor".

4. Regulation and supervision of contract practice.

This represented a long-range program; part might be accomplished in one or two years, and part we were convinced would take four or five years or more for complete fulfillment. This is particularly true of the Public Health program.

A perusal of the reports of the various officers and committees discloses unmistakably that definite and tangible progress has been made toward our objectives, and that the dominant policy of this administration, i. e., *to improve the status of the doctor* has been steadily kept in view.

The Sub-Committee on Legislation of the Welfare Committee is to be credited with securing the passage of two important measures of interest to all physicians. Senate Bill No. 136, amending the Hospital Lien Law so as to include physicians' liens in liability cases, passed the Assembly by a vote of 39 to 14, and after a hearing before Governor Moore, at which opposition was registered by the State Bar Association, insurance companies and large corporations, the Bill was signed April 30.

Assembly Bill No. 373, providing for an emergency appropriation of \$10,000 for the purchase of immunizing material by the State Department of Health for distribution to participating physicians under the plan of the Public Health Committee, passed the Legislature and was signed by the Governor May 2, 1934.

The Society has been honored in the appointment of Dr. Joseph G. Coleman to the *Administrative Council* of the State Emergency Relief Administration. Governor Moore, and Senator (Dr.) Cole, who was persistent in his efforts to have a physician appointed to the Council, share our thanks for this signal recognition.

Through the prestige of the office of Presi-

dent, it was my privilege to aid in getting under way a satisfactory set-up of Medical Relief under the Emergency Relief Administration in Essex County (Newark) and in Mercer (Trenton).

The Executive Secretary, Dr. LeRoy A. Wilkes, is the full-time "Chief of Staff" of

the President and is in daily communication with him. Since his work reflects the administrative details of the office of the President, Dr. Wilkes' report is appended.

May 1, 1934

FREDERIC J. QUIGLEY,
President.

REPORT OF THE EXECUTIVE SECRETARY

By LEROY A. WILKES, M.D.

To the President of The Medical Society of New Jersey:

This report covers the work of the Executive Secretary from October 1, 1933, when he took office, to May 1, 1934.

A resolution of the Trustees passed June 7, 1933, placed all employees of the Medical Society of New Jersey, except the Editor, under the jurisdiction of the President. This action clarified the relations of the Executive Secretary to the Society, both as to his duties and also his chain of accountability. The Executive Secretary has been in close touch with President Quigley almost daily, and has attended to the many details of the executive work associated with the presidential office.

The organization of the Medical Society

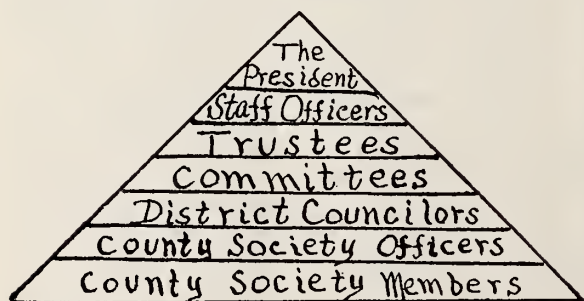


Diagram of the relation of the President to the members of the Medical Society of New Jersey

of New Jersey may be represented by a pyramid of which the President is the apex, and the members of the County Societies are the base. Over two hundred physicians serve the organization in some official capacity. The activities of all these officers center in the Executive Offices in Trenton, of which the Executive Secretary is the Director, having as assistants a secretary and a typist. (A description of the offices is found in the report of the Trustees.)

The scope of the work done by the Executive Secretary covers practically all the

activities of the Medical Societies of the State and the component counties, and their relations to the other health organizations and to the public. By means of this work, the President is informed of events and conditions in the societies, and is enabled to place the facilities of the executive offices at the disposal of those seeking advice and assistance.

The scope of the work done in the executive offices, except that of the Editor of The Journal, will now be described.

1. PUBLIC RELATIONS

The Executive Secretary has been the liaison representative between:

a. State and County medical society officers and committees.

b. Special State and County society committees, coordinating and conducting state-wide health projects sponsored by the Medical Society of New Jersey. Of these there are at present two being conducted in each county:

1. Medical relief for indigents in co-operation with the Emergency Relief Administration of the State of New Jersey.

2. Medical participation in community health programs,—the public health hour project.

c. The State and County Medical Societies and other State and County organizations interested in health either primarily for service (*i. e.* Public Health Departments) or secondarily because of the health implications in their program (*i. e.* schools, welfare organizations, etc.).

d. The Medical Society of New Jersey and the National Health Organizations such as the American Medical Association, American Public Health Association, American Academy of Pediatrics, National Health Council Members, United States Public Health Service, etc.

The promotion of preventive medical services is intimately involved in the aims, and activities of these National Groups and a close coordination of services in approved activities upon a voluntary basis of co-operation should be mutually beneficial and economical.

2. STATE AND COUNTY MEDICAL SOCIETY COOPERATION

The Executive Secretary has visited and spoken to all but three of the component County Medical Societies of the State at their regular meetings. Engagements to visit the remaining ones have been made and all the Societies will have been visited at least once before June first.

All District meetings have been attended and the Emergency Relief Administration and public health projects explained.

The Annual Meeting of Secretaries and Reporters was attended soon after assuming the position of Executive Secretary to the Medical Society.

The Executive Secretary has endeavored to aid Committee Chairmen, upon request, and thereby to relieve them of details which require considerable time and facilities which they do not at times have available.

The overflow of demands upon the President's time and facilities have been turned over to the Executive Secretary, or through him to Committee Chairmen and their Committee members; and reports have been made regularly to the President for his information and use.

A growing sense of understanding of the State Society's program and increasing co-operation in the promotion of organized effort among the component societies is seen; and communications from the Executive offices have on the whole been favorably received and promptly acted upon. The duties of the Secretary in each county society are assuming an importance which is increasingly recognized. The success of the state program and plans, as well as those of the component societies, depends to a considerable extent upon the diligence and ability of the officers chosen—especially that of the secretaries, through whom all communications are received and transmitted.

The Executive Secretary of the State Society has endeavored to serve as a liaison

between the State Society officers and those of the county societies; and also as a liaison between the Medical Society and those other state organizations interested in health service or in the health implications of their work. Medical leadership and guidance is being consistently stressed, and all approaches of lay organizations to the medical profession are being directed to the county medical societies, as a matter of principle and policy. This suggestion has been well received by the lay groups which the Executive Secretary has addressed formally and informally. It is urged that such approaches be given prompt consideration by the county societies in order to recapture the leadership which the medical profession is best fitted to give. The efforts of the county medical society as a body will be closely watched during the coming year for evidence of active leadership and cooperation in community projects involving health protection and restoration.

3. COOPERATION WITH OTHER STATE AND COUNTY AGENCIES

Many executives of public health and welfare departments and of volunteer organizations, will welcome the active participation of the medical profession, *if the medical group is organized* and is represented by the leaders in the state and county medical societies. Definite principles and policies must be pronounced, and the leadership of organized medicine must be evident in the medical members cooperating in community projects.

Individual differences among physicians have often blocked cooperative effort, but now the executives are optimistic regarding the future of *organized* medical participation.

Medical leadership will stand or fall on the spirit shown by the individual members in each county medical society in cooperative efforts in community projects.

State contacts now maintained include the Women's Auxiliary of the State Medical Society; New Jersey Crippled Children's Commission; New Jersey Tuberculosis League; New Jersey Conference of Social Workers; State Department of Health of New Jersey; State Pharmaceutical Association; State Dental Association; State Nursing Association; State Public Health Nurses

Association; State Society for Nurses Education; State Department of Public Instruction; State Department of Institutions and Agencies; State Board of Medical Examiners; State Emergency Relief Administration; State Hospital Association; State Federation of Women's Clubs; State Parent Teachers' Association; State Health and Sanitary Association; State Health Officer's Association; and State Board of Children's Guardians.

County contacts comprise the component county medical societies, county health boards, county tuberculosis and health associations, county welfare organizations, and others.

The principle of medical cooperation in Community Health projects upon a basis of voluntary cooperation is being sponsored by the state and county medical societies.

The necessary medical services are to be furnished and controlled by the county medical society in accord with the principles and policies developed by the county societies through their state organization.

4. JOINT CONFERENCES WITH OTHER STATE SOCIETIES PLANNED

Arrangements for a Joint Conference in May of the Public Health Committees of the New Jersey and the New York Medical Society have been made through the Executive Secretary. The interest of leaders of the Philadelphia County Medical Society, in the public health hour project has been informally aroused and will probably lead to their society joining in the May Conference just mentioned.

The Executive Secretary of the Medical Society of Nassau County, New York, was visited and much of common interest was discussed as to ways and means for practical accomplishment.

5. LEGISLATION

Attention to the details of medical legislation has been the major concern of the Executive Secretary on the days when the Legislature has held its meetings. This legislative work is described in the report of the Sub-Committee on Legislation. The following summary of the duties of the Executive Secretary may be given:

a. Reading proposed medical bills and making synopses of their contents.

b. Issuing a "Legislative Bulletin" to the county societies at frequent intervals.

c. Keeping the members of the society informed of the status of each bill in the Legislature which is of interest to physicians.

d. Obtaining and distributing information regarding the attitude of legislators and of organizations other than medical toward each medical bill.

The *Legislative* contacts and the supervision of selected bills of medical interest have taken a considerable amount of time and effort. The reception of the Executive Secretary by the legislators has been cordial and their attitude has been generally favorable to the interests of the medical profession.

One of the functions of the Executive Secretary has been to list and follow up legislative bills which are of interest to the members of the medical profession. The bills introduced were generally of three types: constructive, defensive, and economic. All bills of interest to the medical profession were listed in the "Legislative Bulletin", issued by the Legislative Sub-Committee of the Welfare Committee in which a brief description of the purpose of each bill was given. These bulletins were sent to the officers of state and component county societies, and to "key men" in each county. Copies of all such bills were obtained and sent to the officers and members of the Legislative Committee and the key men. The members of the Legislative Committee have reviewed these bills and decided, with the help of members experienced in the analysis of legislative bills, which bills to support and which bills to oppose. The recommendations of the Legislative Committee have then been presented to the Welfare Committee for approval. The Executive Secretary has then informed the component county societies, through the "Legislative Bulletin", of the attitude of the state society with regard to each bill and whether it was to be supported or opposed, and the reasons therefor. A special issue of the "Legislative Bulletin" was later prepared, in which were listed, with pertinent comments, the bills upon which the Legislative Committee has decided to *concentrate* at the time.

The key men were selected in each county to serve as contact men to approach directly or indirectly the Senator and Assemblymen

in their respective counties. These key men reported back on the attitude of the legislators regarding special bills, and the Executive Secretary has tabulated their reports and indicated to the President and the Chairman of the Sub-Committee on Legislation when sufficient support had been enlisted for or against a given bill to insure the protection of medical interests, or to make possible the passage of the bill.

The outline of the progress and the status of each bill of interest to the medical profession was followed daily by the Executive Secretary by means of the official "Legislative Index", and "Legislative News", and by personal inquiry among the legislators themselves. The key men and members of the Sub-Committee on Legislation as well as the President were constantly kept informed of any significant changes in status and of the progress made from day to day until the bills passed and were signed by the Governor, or definitely defeated in the Legislature.

6. FIELD AGENT

The Executive Secretary has been a field agent in the promotion, development and co-ordination of medical services rendered by the members of the component county societies as an integral part of the health projects sponsored by the State Medical Society.

At the present time the medical society through its members in the component societies is engaged in two very important projects, to provide organized effort as a medical society to supply

a. Medical relief to indigents in cooperation with the Emergency Relief Administration.

b. Medical participation in diphtheria immunization of infants and pre-school age children—in cooperation with the State Department of Health.

Special reports on these projects are made by the committees in charge of them.

7. ADMINISTRATION

The preparation and distribution of official communications, reports, minutes of meetings, lists, maps, statistics, and graphs are done in the executive offices; as well as accounting, mimeographing, filing and

similar services incident to an executive office.

A considerable proportion of the time of the Executive Secretary and staff is spent upon correspondence, and upon the preparation, mimeographing, and distribution of the reports concerning the work of the various committees attended. The Executive Secretary generally acts as secretary to the committees.

The preparation at intervals of special letters to the legislators, and correspondence incident to the promotion of the projects of the Emergency Relief and Public Health Committees, together with the constant changes incident to the development of such projects, have required a considerable amount of time and effort, as may be gathered from a study of the data regarding the number of stencils, and the number of mimeographed pages prepared and distributed by this department, in addition to the letters daily received and written in the executive offices.

From October, 1933, to the middle of April, 1934, fourteen talks were given by the Executive Secretary and the minutes of fourteen meetings were taken.

Due to the reorganization and establishment of the executive offices the following statistics available at this time cover a period of four months from January, 1934, to the end of April, 1934.

Minutes of meetings	14
Letters received	499
Letters sent (plus 3,000 postal cards)	3,261
Mimeo stencils typed	140
Mimeo pages run off	12,020
Notices sent	12
"Spot maps" prepared	4
"Charts and graphs" prepared	4

A beginning has been made in the collection of significant data in the form of graphs which will illustrate specific accomplishments to date in New Jersey, and help focus our attention and efforts on those projects which promise the greatest return for the money and effort expended. Charts showing organization of allied associations, and their purpose and achievements to date, are also being gradually collected.

Spot maps are being prepared to indicate the activities of the Executive Staff; the special committees, and the county societies.

8. PUBLIC HEALTH EDUCATION

Public health education has been conducted in cooperation with the Woman's Auxiliary of the Medical Society of New Jersey as follows:

a. A Speaker's Bureau for lay organizations, in order to provide able and informed speakers to address the members of such lay organizations upon pertinent and important health aspects of disease prevention and control, and upon the general rules of healthy living.

b. Lists of approved health talks in which the subject matter is provided by medical authorities for use in addresses, newspaper and magazine articles and over the radio.

c. Information on legislative bills supported and opposed by the medical society, introduced in the present session of the Legislature together with their status at given times (Legislative Bulletin).

Public Health Education is carried on by several agencies. The schools provide education upon all subjects and have in recent years provided education in healthy living.

Some of the subject matter included has been out of date and unauthentic because it was selected by the educator without the help of the medical profession. Material gets out of date soon after books are printed. It is the duty of the medical society *upon request* to review the subject matter on health which is to be used in the schools, to insure its value and pertinence.

Public Health Departments issue timely advice on health protection, but at times it becomes stereotyped and unimpressive through constant repetition.

Health programs suited to individual needs at the time given, can be provided only by a physician, and must be preceded by and founded upon a careful survey of the history of the individual, and a careful physical examination made at the time. Over the radio, in the newspapers and magazines comes much misinformation and bad advice. Some of this information is sound and helpful, but the public is not in a position to judge of its value. Commercial interests exploit the public and extol their products.

The medical profession must help offset this danger. The public must also be informed on legislation concerning health and the qualifications of those who would practice the healing art. Legislators must be aided to protect the public against exploitation in the name of health.

Public Health Education material, in which the subject matter is authentic and properly presented, is being gathered from the Americal Medical Association and other reliable sources, for loan to the Woman's Auxiliary Speakers' Bureau operating with the assistance and approval of the county medical society to which the Auxiliary is attached. Pamphlets and occasional books of special merit are being gathered at the central office and will, we hope, some time be developed into a loan library system, by means of which material can be loaned to members, through their county medical societies, particularly to those members who are located in the more rural areas in the State.

A few books and a limited number of periodicals, reprints, radio talks, pamphlets, etc., are now on hand and are being indexed by subject and author for reference.

Partly because of existing commitments and of several engagements subsequently made upon request of New Jersey organizations, the Executive Secretary has delivered several speeches before state and county associations. The subjects were varied but were centered on the theme of organized medical participation in community projects where the cooperation was voluntarily given, even though the services were in some measure compensated. Addresses were given before the

New Jersey Public Health Nurses Association

New Jersey School Nurses Association

New Jersey Conference of Social Work

New Jersey Borough and Township Health Officers

Jersey City Medical Society

Wisconsin State Medical Society at Milwaukee (Guest Speaker)

Essex County Woman's Auxiliary

Burlington County Tuberculosis League

Woman's Club of Laurel Springs

Appointments were kept with other New Jersey organizations, as follows:

Executive Committee on Child Welfare—
New Jersey Conference of Social
Workers

Board of Directors, New Jersey Tubercu-
losis League.

New Jersey Hospital Association, Com-
mittee on Statistics.

Liaison, New Jersey Crippled Children's
Commission.

9. THE JOURNAL

The Executive Secretary has been in al-
most constant communication with the Edi-
tor of The Journal, who shares the Execu-
tive Offices with him. It is only by this
hearty cooperation that the activities of the
society can be summarized and published in
permanent form, so that they may be avail-
able not only to the members of the state
society, but also to those of the societies of
other states, and to other workers in the fields
of medicine and public health everywhere.

The Executive Secretary has prepared the
following articles for The Journal:

Public Health Committee meeting
Emergency Medical Relief Program
Public Health Committee Projects
Report on the Two Projects Now Being
Conducted by the State Society as Com-
munity Services
Medical Legislation.
Adventuring in Medical Co-operation
Changes Seem Inevitable
Current Legislation

10. FINANCIAL STATEMENT

An advance fund of \$500.00 was depos-
ited in the Broad Street National Bank of
Trenton in November, 1933, and monthly
itemized statements of expenditures are ren-
dered to the Chairman of the Finance Com-
mittee (Dr. North) who, after approving the
expenditures made has forwarded a state-
ment of such approved expenditures to the
Executive Secretary.

All receipts and cancelled checks are filed
in the Executive Offices in Trenton for au-
diting purposes.

Petty cash of approximately \$25.00 is
kept on hand, and salaries and bills are paid
by check.

A statement of expenditures is included in
the monthly report made by the Executive
Secretary to the President of the Medical So-
ciety and the Chairman of the Board of Trus-
tees.

The expenditures for travel are below av-
erage so far this year because no *National
Conventions* have been attended and the Sec-
retary has only very occasionally stayed over
night on any trips made about the state to
attend meetings.

A tentative budget for the fiscal year 1934-
1935 has been submitted to the Chairman of
the Finance Committee for the conduct of
the work of the Executive Secretary.

LEROY A. WILKES, M.D.,
Executive Secretary.

May 1, 1934.

REPORT OF THE SECRETARY

By J. B. MORRISON, M.D.

To the House of Delegates:

We will open the 168th Annual Convention
of the Medical Society of New Jersey, on
Tuesday, June 5, 1934.

The House of Delegates, according to the
last amendment to the Constitution, shall be
composed as follows:

Elected delegates	174
Trustees	16
Judicial council member	1
Fellows	12
Total	203

Component society officers shall see that
their representation is complete. Notification
has been sent to the secretaries of the com-
ponent societies whose representation has been
increased according to the provision of the
amended constitution.

We have lost by death 48 members—a
heavier toll than usual. Among these was
Dr. W. Blair Stewart, of Atlantic County, a
very active delegate, whose counsel and advice
the State Society has enjoyed over a long pe-
riod of years. His early demise will be a great
loss to the society.

On the 1933 official list we carried a total

membership of 2750. The official list for 1934, which will appear with the May JOURNAL, will carry a total of 2754. Thus, in spite of the continued depression, we have held our own in membership. We have besides an Associate Membership of 109. There have been 212 new members elected during the year.

I would earnestly call your attention to the bill introduced in Congress, with the backing of Labor, for unemployment insurance. This bill will in all probability pass both houses of

Congress this year or next year. We have seen in every country abroad where this measure was adopted, that it was almost immediately followed by the adoption of socialized medicine. Thus we must be prepared to have the medical profession in New Jersey well informed on this project; and if possible, to line it up 100 per cent back of whatever plan our State Society deems acceptable to them before we offer the coöperation of our Society.

May 1, 1934 J. B. MORRISON, *Secretary*.

PRELIMINARY REPORT OF THE TREASURER—1933-34

By E. J. MARSH, M.D.

To the House of Delegates:

As the fiscal year does not end till May 31, a complete report at this time is impossible. The following is based on the actual transactions for ten months together with estimates based on this experience and compared with the experience of former years. Certain individual items are final, and have been distinguished by the letter (f). As the report is necessarily only approximate, cents have been omitted in the interest of economy, figures being given in terms of the nearest whole dollar.

RECEIPTS

Balance, June 1, 1933	\$24,635
Assessment	37,500
Journal receipts	6,750
Interest	800
Miscellaneous	425
	<hr/>
	\$70,110

PAYMENTS

Publication	\$11,656
Office:	
Clerical	\$2,159
Expenses	1,475
Travel	1,440
Moving and furnishing	1,271 (f)
	<hr/>
	6,345

Welfare	1,300
Salaries:	
Secretary	1,500 (f)
Executive secretary	5,667 (f)
Field secretary	1,333 (f)
Editor	4,633 (f)
Secretary's expenses	1,840
Treasurer's expenses	60
President's expenses	200
Trustees and minor committees' expenses	300
Printing, postage and stationery	2,300

Annual meeting, 1933:

Program and arrangements	996 (f)	
Scientific exhibit	290 (f)	
Credentials committee	286 (f)	
Guests	130 (f)	1,702 (f)
County secretaries' conference	94 (f)	
A. M. A. Delegates; Railroad fares	233 (f)	
Conference of Professional Societies	200 (f)	
Honorarium	100 (f)	
Viewing boxes	135 (f)	
Miscellaneous	50	
Balance, estimated, May 31	30,462	

\$70,110

E. J. MARSH,
Treasurer.

April 1, 1934

REPORT OF THE BOARD OF TRUSTEES

WELLS P. EAGLETON, M.D., Chairman

To the House of Delegates:

According to the constitution of the Medical Society of New Jersey, Article VI, the Board of Trustees "shall be the Executive Body" of the Society; while Article V states, "The House of Delegates shall be the Legislative Body".

The By-Laws, Chapter VI, Section 5, state, "The Board shall exercise general supervision over the affairs of the society with authority to act for the society between annual meetings; and to perform the following functions". Nine functions are enumerated, typical ones being, "To supervise the work of the Publication Committee; to determine all salaries; and to fill vacancies in all offices".

At the meeting of the Board of Trustees in April, 1932, a plan was unanimously adopted to make the Society with all its activities revolve around the President during the year of his presidency; to familiarize the incoming presidents with certain branches of the organization; to have the Board of Trustees at each meeting in constant touch with the activities of the Society; as well as to have the chairman of the important committees know what the Trustees are doing.

The Trustees have held frequent meetings, during the fiscal year, and have transacted business of importance.

Following the Annual Meeting, the Trustees met on June 25, 1933, and Dr. Wells P. Eagleton was unanimously elected Chairman, and Dr. H. W. Nafey was elected its Secretary.

A vote of thanks was extended to Dr. Andrew McBride for the very able and impartial service which he had rendered to the State Medical Society of New Jersey as Chairman of the Board of Trustees.

It was decided that the term of office of any chairman of the Board of Trustees shall be for not more than two terms.

Dr. Eagleton announced that his term of office on the Committee on Finance and Budget as a Trustee member had expired; and he stated his opinion that no member should serve on more than one committee. Since he had been elected Chairman of the Board of Trustees, he recommended that Dr. Harry R. North be appointed as the Trustee Member of the Finance and Budget Committee. This recommendation was adopted; and Dr. Herschel Pettit, of Ocean County, was elected as the delegate member to succeed Dr. North.

On June 7, 1933, a special committee consisting of the President, the President-Elect, the two Vice-Presidents and the Chairman of the Board of Trustees made a report clarifying the accountability of the employees and stating that all paid employees, with the exception of the Editor, shall be under the jurisdiction of the President. This report was adopted by the Trustees.

The Trustees also adopted a resolution that The Journal shall be under the control of the Publication Committee in conjunction with the Board of Trustees.

The Board also decided that the office of Executive Secretary shall be divorced from that of the Editor; and that the combined salaries of the two offices should not exceed \$12,500. The change was suggested in order to provide a full-time Executive Secretary, as due to the change economic conditions, it was thought necessary that physicians take a more active part in economic, political, and public health matters.

The Trustees at first offered the position of Editor of The Journal to Dr. Henry O. Reik, who as Editor for nine years had enlarged and increased the influence of The Journal.

At the regular quarterly meeting of the Trustees held November 7, the Trustees unanimously approved the unanimous recommendations of the Publication Committee, the President, and Chairman of the Board of Trustees that Dr. Alfred E. Shipley be appointed Editor. Dr. Shipley was Professor of Preventive Medicine at the Long Island College Hospital Medical School and Chairman of the Committee on Public Health of the Kings County Medical Society.

The Board appointed Dr. LeRoy A. Wilkes as Executive Secretary, at a salary of \$6,000 per annum, with travel allowance not to exceed \$1200 a year, or six cents per mile when using his own car; and with a vacation of one month at a time to be authorized by the Board.

After serving three months, Dr. Shipley asked to be released of the Editorship, since Dr. S. S. Goldwater, Commissioner of Hospitals of New York City, was anxious to appoint him as his first deputy and Dr. Shipley felt that the New York position offered an opportunity for greater service. His resignation was accepted with regret.

The Board then acted on the unanimous recommendation of the Publication Commit-

tee, and of the President, and appointed as Editor Dr. Frank Overton, who had been Editor of the New York State Journal of Medicine for ten years. Dr. Overton assumed the editorship on February 1, 1934.

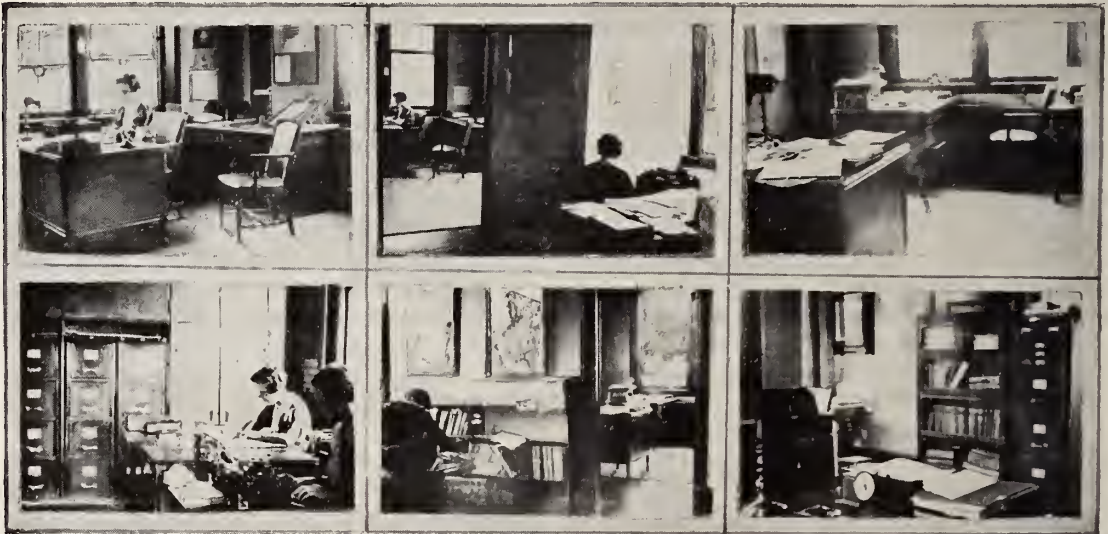
Mrs. Ethel Taneyhill, who had served the society faithfully and efficiently as Field Secretary with special educational duties, was invited to continue in the service of the society. Mrs. Taneyhill stated that she had other plans for the future and consequently could not accept the offer. It was voted that her full salary be continued up to the time of the termination of her connection with the society.

The Board expressed its recognition of the

tatives of the medical societies of New Jersey, New York and Pennsylvania had met every four months for eight years, for the discussion of society problems of mutual interest. The Board was favorable to a renewal of the conference after a plan suggested by President Quigley providing for the return of New York.

EXECUTIVE OFFICES

One of the actions of the Board of Trustees was the establishment of central offices of record and administration by a special committee consisting of Drs. North, Newcombe,



EXECUTIVE OFFICES OF THE MEDICAL SOCIETY OF NEW JERSEY

Executive Secretary room.

Editorial room, looking into Executive Secretary room.

Editorial desk.

Reception room.

Room of Executive Secretary, looking into Editorial room.

Filing corner of Editorial room.

value of the work of Miss Margaret Mahoney, Secretary to the Editor, and voted that her full salary be paid to her up to the time of the termination of her connection with the society; and that in addition she be presented with one hundred dollars as an honorarium in appreciation of her services and the general excellence of her work.

The Trustees adopted a resolution offered by the President of the Society, Dr. Quigley, urging the Governor to appoint a physician as Commissioner of Labor, because the work was largely medical.

The Trustees expressed their regret that the Medical Society of the State of New York had sent a formal notice of its withdrawal from the Tri-State Conference, in which represen-

Ely, and Herrman, at a rental of seventy-five dollars a month.

While the work of the average county medical society is conducted by its members serving voluntarily, the activities of the Medical Society of New Jersey require the full-time services of a paid staff and the facilities of a well-equipped office, in order that the officers and committeemen may have the ready means for carrying out the policies and plans of the State Society; and may maintain intimate contact with the county societies and their members, and be ready to give them prompt assistance and advice.

The Medical Society of New Jersey is now entering its first year of the centralization of the administrative, journal, and clerical work

in its own executive offices, which were opened on October first, 1933. The personnel of the

The executive offices of the State Society are now in the state's capitol, Trenton, the center of the official life of all departments of the state government. They are located in the American Mechanic Building, at 137 East State Street.

The rooms are arranged in the form of an L, each with its own entrance from the hallway, and yet all are connected through doors which may be closed when privacy is desired.

The equipment of the rooms has been chosen for its adaptability to the needs of the Society. The floor space and equipment, and the assignment of the rooms, are shown in the accompanying photographs and diagram.

The executive offices with their centralization of personnel and records symbolize the unity of the members of The Medical Society of New Jersey, its aims and actions looking for a broader service for the doctors of New Jersey; and affords efficient integration and safeguard of the interests and activities of the Society.

WELLS P. EAGLETON,

May 1, 1934

Chairman.



Diagram of floor plan of the Executive Offices

staff consists of the Executive Secretary of the State Society, and the Editor of The Journal, with their secretarial assistants.

REPORT OF THE JUDICIAL COUNCIL

By CHRISTOPHER C. BELING, M.D.

To the House of Delegates:

The Judicial Council is composed of the elected councilors of the five councilor districts, and is charged with two duties:

- (1) To act as a board of censors.
- (2) To supervise and assist the county societies.

The Council reports that no matters of an ethical nature have come before it, but that the year has been one of great activity in all the county societies.

The agreement which the Medical Society of New Jersey made with the Emergency Relief Administration of the State of New Jersey, necessitated the formation of a Committee on Medical Relief. The President appointed the Councilors on the committee. On the recommendation of the President, Mr. John Colt, Director of the Emergency Relief Administration appointed the Councilors of the First and Second Districts, and Dr. Charles C. Schlichter to serve as a Medical Advisory Committee to the Emergency Relief Administration. Dr. Spencer T. Snedecor,

Councilor of the Second District was made chairman of these committees. The organization and supervision of the plans for medical relief work in their respective districts placed many additional duties upon the councilors.

For the past few years the councilors have been called upon to hold annual District Meetings and to cooperate with other committees. This last year the amount of work of the councilors reached its maximum, but there is no doubt that the work of the Judicial Council and particularly of the individual councilors will continue to increase still further. As the state society keeps spreading its activities, it will no doubt give the councilors more work to do.

COUNILOR DISTRICTS

The Judicial Council, therefore, wishes to call the attention of the society to the importance of considering a *rearrangement of the Councilor Districts*. As at present constituted the grouping of the counties into five districts is uneven, and lacks proper unity and

common interests; and in some instances the counties are separated from one another by great distances.

To create a closer organization of the districts and more efficient contacts, to lessen the increasing burden of councilor duties, and to promote a better liaison between the state society and its component units, the Judicial Council recommends that the number of Councilor Districts be increased from the present number of five, to seven; and that a Councilor be appointed to each district. The following redistribution of the counties among the districts is suggested:

First District: Essex, Union, Somerset.

Second District: Hudson, Bergen, Passaic.

Third District: Morris, Sussex, Warren.

Fourth District: Middlesex, Monmouth, Ocean.

Fifth District: Mercer, Hunterdon, Burlington.

Sixth District: Camden, Gloucester, Salem.
Seventh District: Atlantic, Cumberland
Cape May.

In making these recommendations the council realizes that it may not be feasible to make the changes under the present constitution.

Numerous district councilor meetings have been held during the year.

The councilors should be more definitely informed regarding malpractice suits, and then enable to take an active interest in following them up.

CHRISTOPHER C. BELING,
Chairman

SPENCER T. SNEDECOR,
Secretary

FRANK G. SCAMMELL,
JAMES A. FISHER,

May 1, 1934 ALDRICH C. CROWE.

REPORTS OF THE COUNCILORS OF THE FIVE COUNCILOR DISTRICTS—1933-34

FIRST COUNCILOR DISTRICT

Christopher C. Beling, M.D., Councilor
Union, Warren, Morris, and Essex Counties.

During the past year the counties comprising the First Councilor District have been very active. The meetings were well attended. Warren County held a joint meeting with Morris and Sussex, which I had the pleasure of attending. Morris County has had regular meetings and also special meetings. Union County and Essex County have both developed medical economic programs and are carving them out along with their scientific activities.

All of the county societies of the First District have entered whole-heartedly into the Emergency Relief work as outlined by the state society.

This year a joint meeting of the First and Second Councilor Districts were held at the Academy of Medicine of Northern New Jersey on April 12, when the Essex County Medical Society gave up its regular meeting to allow the Councilors' District Meeting to be held.

It has been a pleasure to attend the various meetings and I wish to take this opportunity to thank the various counties for their kind reception.

SECOND COUNCILOR DISTRICT

Spencer T. Snedecor, M.D., Councilor
Sussex, Bergen, Hudson and Passaic Counties

A brief review of the societies of Northern New Jersey shows them to be active and progressive.

Lawsuits against physicians have not been successful. As near as we can recall, one case was settled, two were non-suited, and Dr. Ash's suit in Paterson was called a mistrial and led to the uncovering of the jury-fixing ring in Passaic County. Constant vigilance, however, must be maintained in order to keep these suits under control.

Reports of county society meetings show them to be constantly rising to a higher standard in the scope and efficiency of their work.

THIRD COUNCILOR DISTRICT

Frank G. Scammell, M.D., Councilor
Mercer, Middlesex, Somerset, and Hunterdon Counties.

As a councilor of the Third District, I am happy to state that the county, its component societies, Mercer, Middlesex, Somerset, and Hunterdon, from the membership standpoint, are a unit in the policies outlined by the state

society. There has been a noticeable decrease in the number of malpractice suits against the members of these several counties. This indicates that there is being developed a better professional relation in the care of the patients treated. The harmony of the members in the several counties is, in my judgment, all that could be desired. The clarification of the Emergency Relief conditions by the Legislature has minimized the need of special attention to these several counties. My visitation to these several counties has been very pleasant and I take this opportunity to publicly declare my thanks for their kind reception of their councilor from the Third District.

It may be of interest to know that on the night of our visitation to the Somerset County Medical Society, and I am stating this only as a record, the temperature reached 29° below zero.

FOURTH COUNCILOR DISTRICT

James A. Fisher, M.D., Councilor

Camden, Burlington, Ocean, and Monmouth Counties.

The activities in the Fourth Councilor District in the past year have been principally organization and operation of the Emergency Relief Association, which has necessitated considerable correspondence and conferences in order that difficulties arising in the various counties, due to misunderstanding and interpretation of the regulations, might be clarified. There has also been considerable activity throughout the counties in organizing the Public Health Program. I am glad to report that both of these projects are functioning with a considerable degree of success, except for some minor details in the operation of the Emergency Relief, which the committee has

under consideration and hopes to be able to rectify to the entire satisfaction of the medical profession.

The Fourth Councilor District Meeting was held in Asbury Park at the Berkeley Carteret Hotel on April 25. Professor Edward Chamberlain of the Radiology Department of Temple University, was the chief speaker of the evening on the subject Hodgkin's Disease, Lymphoblastoma, and Leukemia.

FIFTH COUNCILOR DISTRICT

Aldrich C. Crowe, M.D., Councilor

Cape May, Cumberland, Atlantic, Gloucester and Salem Counties

The work done by the Councilor of the Fifth District this year has been one primarily concerned with the workings of the Emergency Relief Administration as it affected the medical men in the district.

Various meetings and conferences have been held at different parts of the district. At these meetings we attempted to straighten out the many questions arising concerning the administration of this work.

One meeting was held at Cape May Court House. This meeting dealt with the public health program of the state society. The meeting was well attended and representatives from the public health committees of the five counties of the district were present.

There is one malpractice suit in the Fifth District. The settlement of this suit is still pending.

My impression of the work of the state society this year is that it has made great progress, and there is a keener interest being shown by the individual members in the activities of the state society than ever before.

REPORT OF THE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

By JOHN F. HAGERTY, M.D.

To the House of Delegates:

The annual meeting of the American Medical Association was held June 12-16, 1933, in Milwaukee, Wisconsin, and was attended by the entire New Jersey delegation, consisting of Drs. John F. Hagerty, Walt P. Conaway, Ephraim R. Mulford and Bert S. Pollak. Dr. Hagerty was appointed Chairman of the Reference Committee on Rules and Order of Business.

One frequently hears the questions: "Why have a State Medical Society?" and "Of what use is the American Medical Association?" A very excellent answer to all such questions will be found in reviewing the activities of the Association. The report of the Board of Trustees contains well-considered opinions upon such subjects as: legal medicine and legislation, health and public instruction, medical

economics including contract practice, group hospitalization, workmen's compensation, and group practice.

The report of the Judicial Council, with its recommendation upon contract practice, which was adopted by the House, is important enough to be stated here:

"By the term 'contract practice' as applied to medicine is meant the carrying out of an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization or individual, to furnish partial or full medical services to a group or class of individuals for a definite sum or a fixed rate per capita.

"Contract practice *per se* is not unethical. However, certain features or conditions, if present, make a contract unethical, among which are:

"(1) A solicitation of patients, directly or indirectly.

"(2) Under-bidding to secure the contract.

"(3) Compensation inadequate to assure a good medical service.

"(4) Interference with reasonable competition in a community.

"(5) Free choice of a physician prevented.

"(6) Conditions of his employment making it impossible for the doctor to render adequate service to his patients.

"(7) A contract, because of any of its provisions or practical results, contrary to sound public policy."

The members of the House of Delegates voiced their approval of the various activities conducted by the American Medical Association, among which the following are outstanding:

The Council on Medical Education and Hospitals during the last thirty years has been engaged in raising the standards of medical education and hospitals.

The Council on Pharmacy and Chemistry exercises vigilant supervision over drugs, surgical instruments, and appliances, foods, beverages, etc., and investigates 12,000 questions and complaints annually.

The publication of the *Journal*, conceded to be the outstanding medical journal of the world, and it should be remembered that the fund received through publication of the *Journal* enables the Association to carry on its multitudinous activities.

The labors of the officers in their efforts to aid and coördinate the work of the profession throughout the country.

Some of the more specific matters considered and approved by the House of Delegates were:

The objections of Presidents Cary and Lewis, strongly expressed, to the hospitalization of veterans for non-service connected disabilities.

Adoption of the motion made by Dr. Leigh, of Virginia, that presidents of constituent societies be made ex-officio members of the House of Delegates.

The Speaker's reference to the value of full reports of sessions of the House to state societies.

Action of the Trustees in continuing to send the *Journal* to members, when delinquent, on promise to pay (the By-Laws provide that a Fellow who, for one year, has failed to pay his annual fellowship dues, shall forfeit his fellowship thirty days after notice of his delinquency has been mailed to his last known address).

The decision on the status of medical students educated abroad, that the license to practice must be obtained in the countries in which they received their medical education; the suggestion to do away with state board examinations and accept certificates of medical colleges.

A plan for regulation and control of specialism by the American Medical Association.

Tabling of the resolution calling for investigation of birth control. (A similar resolution met with the same fate last year.)

The programs for the scientific sessions were extremely interesting and comprehensive, and the meetings were well attended; while the scientific exhibit, as heretofore, proved the most interesting feature of the meeting. The arrangements for holding meetings and housing the exhibit were perfect, and those privileged to attend received an excellent impression of recent progress in medicine, surgery and pathology. Especial attention this year was devoted to poliomyelitis, cancer, endocrine disturbances and their effects upon growth and bone pathology, and the value of cholecystograms and urograms in demonstrating pathology of the biliary and urinary tract.

JOHN F. HAGERTY
WALT P. CONAWAY
EPHRAIM R. MULFORD
BERTHOLD S. POLLAK

May 1, 1934

REPORT OF THE COMMITTEE ON SCIENTIFIC WORK

To The House of Delegates:

The Committee on Scientific Work hopes that the members of the society will find the subjects selected for the program of the Annual Meeting interesting and instructive; and regrets it could not accept all the papers submitted, due either to the program having been completely arranged soon after appointment of the committee; or the subject not being considered for presentations this year.

The committee appreciates the efforts of the various sections in arranging section programs, which are most excellent; and of Drs. John Gray and George Reitter in arranging the

scientific exhibit which presents actual work of New Jersey physicians.

It is the wish of the committee to have members present titles of papers early, to avoid disappointments where possible. The members of the committee and the president of our society have been most unselfish and are arranging a program of selected subjects which they believed to be of the greatest good to the greatest number of members of your society.

LOUIS C. LANGE,

Chairman

May 1, 1934

RALPH K. HOLLINSHED,

CLARENCE C. ANDREWS.

REPORT OF THE PUBLICATION COMMITTEE

By HENRY C. BARKHORN, M.D.

To the House of Delegates:

The duty of the Publication Committee of The Medical Society of New Jersey is defined in a single line of the By-Laws, Chapter VIII, Section,—“It shall publish and distribute the Journal”.

THE JOURNAL

Monthly numbers of *The Journal of The Medical Society of New Jersey*, are published in accordance with the precedents evolved and established during the thirty years of its existence. It reflects the point of view of the modern practitioner of medicine in New Jersey, and his attitude toward all phases of service rendered by the medical profession.

While the current numbers of The Journal record waves of thought raised by local winds of observation and opinion, yet the irresistible rise of the tide of progress in the practice of scientific medicine becomes apparent only when the issues of the journal are compared by decades.

Four distinct periods of development of the supply of medical service are easily recognized, and may be named as, (1) authority; (2) demonstrations; (3) democracy; and (4) coöperation.

FIRST PERIOD—THE RULE OF AUTHORITY

During the first period of the supply of medical services, which extended through all the nineteenth century, the State Medicine Society was the central source of power and authority. The condition in New Jersey during that century may be represented by a dia-

gram of concentric circles with the state society at the center, radiating waves of scientific influence outward through 21 county societies to their individual members. The activities and programs of all the medical societies were entirely scientific, and medical

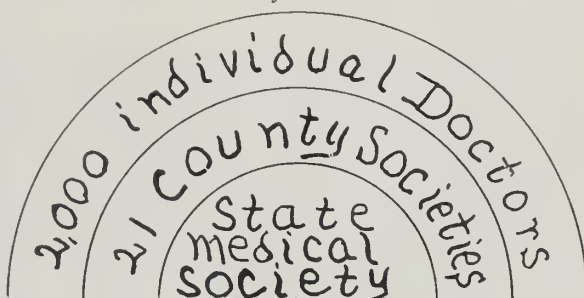


Diagram 1—The State Medical Society, the Central Authority During the Nineteenth Century

journals contained only technical articles. The State Medical Society was closely allied with the medical schools, and had the power of conferring medical degrees, and issuing licenses to practice medicine. The state medical society of Maryland still retains its original name of “The Medical and Chirurgical Faculty of Maryland”. At the end of the first period scientific medicine was firmly established as the basis of medical practice by all physicians, and as almost the only topic of discussion in medical society meetings and medical journals.

SECOND PERIOD—DEMONSTRATIONS

The second period of the supply of medical services extended through the first quarter of the twentieth century, when depart-

ments of health and lay health organizations assumed an increasing importance as the central source of power and authority in the delivery of the services of medicine, displacing medical societies and individual doctors to secondary positions, as is shown in the second diagram. The movement was hastened by the World War, in which one fifth of the active physicians of the country became engaged and learned from first-hand experience of the vital necessity of medical organization by phy-

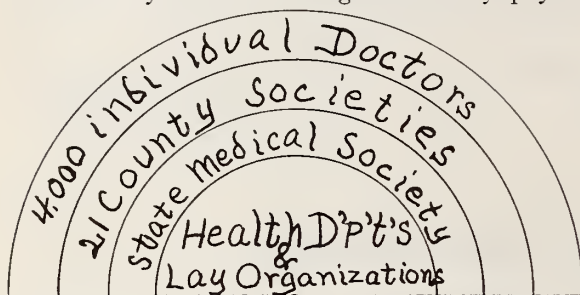


Diagram 2—Assumption of Leadership by Organizations Outside the Medical Profession up to 1925

sicians in the active practice of their profession. Medical journals of the period were full of articles on preventive medicine and immunizations, and of new methods of bringing all forms of medical service within reach of all classes of people.

This was also the period of "Demonstrations" by free clinics and public health nursing, in which family doctors were urged to *donate* their time in altruistic services which were often unappreciated by the recipients, and by the people generally. The discussions and criticisms regarding the various plans put forth by non-medical promoters have been duly recorded in the journals of the period.

THIRD PERIOD—DEMOCRACY

The third or present period in the supply of medical services, which began about 1925,

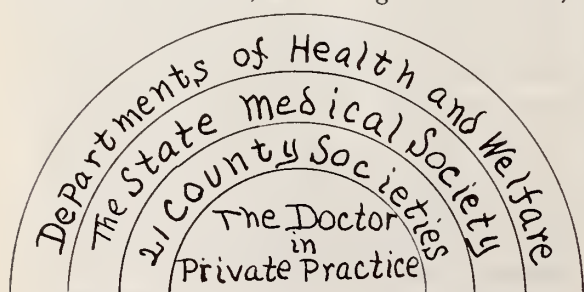


Diagram 3—The Doctor's Office, the Medical Center in 1933

is characterized by the rise of *democracy* in medicine. The present trend in the practice of medicine is to place the individual practicing physician at the center of every organiza-

tion for the delivery of medical services, as is shown in the third diagram. The office of the practicing physician is already becoming a *medical center* in his community; and he is delivering medical services to patients whom welfare officers and public health nurses refer to him. He will not *donate* his services under the new system or bear the entire burden of supplying medical care to the poor; but he will receive pay, just as the welfare officers and public health nurses do.

The county medical society today is a true democracy. Every member has an equal voice in its management, and contributes to its activities according to his temperament and talents.

ADMINISTRATIVE MEDICINE

No matter what the system of distribution may be, the actual delivery of medical service must be made by an individual doctor in friendly contact with the individual patient. The Medical Society of New Jersey stands firmly on the principle that the physicians in private practice in every community are equipped with both the means and the will to plan every form of medical service that may be required; and to deliver it more efficiently, economically, and satisfactorily than any other agency. But the delivery of the medical service by the doctor requires the participation of lay workers and the development of agreements with governmental officials, welfare organizations, and educational agencies, in order that each group may realize its particular responsibility, and make its proper contribution to the development of an efficient service. Hence there has arisen a system of medical service which may be called "Administrative" medical practice, and which is done principally through the medical societies. The officers of the medical societies of the counties and of the state are the liaison agents between the private practitioners of medicine and the welfare officials; and the medical significance of their administrative duties is as great as that of the family physician advising a mother how to protect her well children from one who has scarlet fever.

FOURTH PERIOD—CO-OPERATION

The physicians of New Jersey and all other health agencies of the state, are now entering upon a fourth period in the supply of medical services—that of *coöperation*—in which the central consideration is the medical and health needs of the community. To supply those needs is the desire of every group of health workers and of every patriotic citi-

zen; and on this platform all groups can unite.

New Jersey has 4,000,000 inhabitants, of whom an average of 200,000 are under the care of some physician on any given day. The most prominent factor in preventing the delivery of adequate medical service to a large

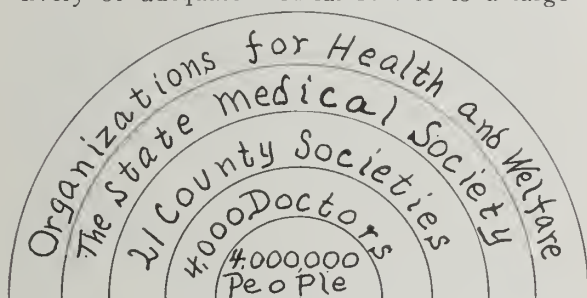


Diagram 4—The New Principle of Coöperation in Supplying the Medical Needs of the People

proportion of these sick persons has been their economic status. How the physicians of New Jersey have achieved a large measure of success in eliminating this factor is told by the Medical Advisory Committee to the Emergency Relief Administration in its annual report which appears on page 288 of this Journal. The principles of that relief are also outlined in the April Journal, page 189, in an editorial entitled "Adventuring in Medical Coöperation".

Other factors besides economics enter into the equitable distribution of medical services, among them being social, political, educational, and moral considerations, all of which will be set forth and discussed in The Journal as they develop. The Journal will reflect the attitude of the members of the county societies as they discuss all sides of these questions. That every physician is giving serious consideration to these problems of medical relationships is shown by the fact that they are the subjects of the official addresses and reports of the great majority of the officers of every county society.

DEPARTMENTS OF THE JOURNAL

A standard issue of The Journal at present consists of 88 pages. This size has been determined naturally by a remarkable regularity in the influx of available material.

The published material may be classified under four divisions. The number of pages in each department for the first four months of 1934 is shown in the following table:

	Editorials	News	Scientific	Advertising
January	6	19	37	26
February	6	19	37	26
March	6	18	38	26
April	7	17	38	26

ORIGINAL ARTICLES

The department of *original articles* contains scientific papers on subjects connected with the practice of medicine. These papers constitute a course in graduate instruction, in fact most of them have been read before medical societies for teaching purposes.

The Publication Committee recommends that the following principles regarding the acceptance of papers be recognized:

(1) The articles shall have been read before a medical organization in which members of the Medical Society of New Jersey take an active part.

(2) Requests for the publication of the papers shall come from the officers of those societies.

(3) Every article shall be subject to editing, condensation, or expansion; but the final copy shall be submitted to the author and receive his approval before it is published.

(4) The subjects of articles shall be those which appeal to general practitioners, who constitute the largest group among the members of the state society.

NEWS

The Journal carries up-to-date information regarding the activities carried on by The Medical Society of New Jersey, and its component county societies, and emphasizes the parts taken by the individual members. The efficiency of the system of reporting the activities of the county societies of New Jersey by their own local reporters may be correctly rated at 80 or 90 per cent—a high standard according to the system of marking compositions in schools and college. A record of every item of business transacted by a county society is valuable, for all forward movements have small beginnings which may be overlooked unless they are recorded as a matter of routine. The inclusion of the names of the participants in society discussions and activities is evidence of the reliability of the records and reports.

EDITORIALS

It is the plan of the Publication Committee that the editorials shall deal directly with the policies and activities of the medical societies of the state and counties of New Jersey. The editorials will be constructive rather than critical, and will support the principles and procedures which are adapted to the physicians of New Jersey of the present day.

INDEXING

The journals of the medical societies of the several states are the principal source of information regarding the activities of the societies of those states and their component county societies; and the reputations of these states will depend largely on those records.

It is the policy of the Publication Committee to make the *Journal* the repository of the records and activities of the state and county medical societies. Only those who deal constantly with records and precedents can appreciate the full value of complete reports and records available in an accessible form. All the articles and the items of activities recorded in *The Journal* will be fully indexed and issued as an integral part of the December number, which will complete volume 31 of *The Journal*.

FINANCES

This year has been most difficult, yet also most interesting for the Publication Committee. Despite the rapid changes there has been no confusion. The *Journal* has been published regularly and on time.

The committee has decreased the number of departments and hopes to publish about 750

pages of reading matter each year instead of 1000 pages. We should be able to do this on 80 per cent of our budget, thus saving almost \$2500 for the State Society.

Advertisements have continued about the same as last year. Because of the decrease in national advertising over a period of years, we have conducted a small local campaign in the various counties. Due to the coöperation of the county officers, we have many promising leads which may bring in additional income to the *Journal*.

As our fiscal year does not end until June 1, no detailed financial report is included. Except for the saving of about \$2,500, it will be essentially the same as last year.

IDEALS

The Publication Committee reaffirms the principles and ideals set forth in an editorial on "The *Journal*", which was printed in the issue of January, 1934. It is the committee's desire that the *Journal* shall be something more than the formal organ of an impersonal society; and that each issue shall be a *family* communication to the physicians working together in intimate friendship.

HENRY C. BARKHORN,
Chairman.

May 1, 1934

REPORT OF THE FINANCE AND BUDGET COMMITTEE

By HARRY R. NORTH, M.D.

To the House of Delegates:

The Committee on Finance and Budget met on Sunday, April 15, 1934, and went over the computed expenses of the Society for the year 1934-35.

Every effort is being made to curtail expenses. It will be impossible to give the per capita assessment at the present time, but it will be kept as low as possible.

HARRY R. NORTH,
Chairman.

May 1, 1934

REPORT OF THE COMMITTEE ON PROGRAM AND ARRANGEMENTS

By W. J. CARRINGTON, M.D.

To the House of Delegates:

The primary duty of the Committee on Program and Arrangements is to make provision for the accommodation of the several meetings, exhibits, banquets, and other features of the annual meeting. The Committee is also charged with issuing a printed program of the sessions and other events.

The details of the local arrangements depend very largely upon the requirements of the several officers and speakers, but so far as possible their needs have been anticipated in the light of the experience in past years.

The Committee has given much time and thought to the financial aspects of the arrangements, and has prepared estimates of

the costs of printing the programs and announcements; of the members' badges; of the rooms for section meetings and the hire of lanterns and operators; of the orchestra for the banquet; and of other features which involve the expenditure of money. It is the opinion of the committee that a considerable saving could be effected by adopting modest standards of size, style, and ornamentation in programs, and other features which the committee must provide.

W. J. CARRINGTON,
Chairman.

JOHN W. GRAY
W. D. OLMSTEAD

May 1, 1934.

THE COMMITTEE ON MEDICAL DEFENSE

By CHRISTOPHER C. BELING, M.D., *Chairman*

To the House of Delegates:

According to the information furnished by the Insurance Company up to April 1, 1934, there are 96 pending claims, of which 46 are cases reported this year. This number does not include claims made against physicians in Hudson County and South Jersey. The final report, which will be presented to the Medical Society at the Annual Meeting, will contain complete information for the year ending June 1, 1934.

Our experience during the past year shows that the number of suits threatened have increased. Many of the claims upon investigation have shown little or no merit, but these cases, where suit has been entered, have involved considerable expense on the part of the company to defend such actions. The company, however, has had several serious damage suits, one of which only recently involved a jury verdict of \$20,000 against the doctor. Two other cases were settled, one for \$3500, and one for \$1250. Numerous other cases on which settlement were made vary from \$200 to \$750.

The total cost in defending law suits on claims reported during the past year amounted to \$6,939.94, with settlements amounting to \$9,391.56. The total cost of 32 out of 96 cases pending was \$16,331.50.

Many inquiries have been made during the past year as to what constitutes a member in good standing, according to the terms of this insurance contract. It was pointed out by the secretary of the state society that the state society did not deal with the individual, and that the levy was on the component societies; and only the names sent to the treasurer of the state society were carried into the official list of members in good standing. In many county societies delinquent members are carried on the roll, although their state assessments have not been paid. These members have felt that they were in good standing,

when as a matter of fact, they were not. In one instance this question was raised in one of the county societies.

The committee therefore recommends that the state society take the matter up with the component county societies so that there will be no misunderstanding as to the rights and privileges of the doctors who are insured under this special contract.

Some arrangement might be made by the county societies, in special instances, to extend the time limit for the payment of its dues; but in this case, the county society should pay the state assessment so as to keep the member in good standing in the state society.

For the information of the members the committee draws attention to paragraph 6 of the *Protective Insurance Policy* issued to members of the State Medical Society, which states as follows:

"Termination of membership of an assured in the Medical Society of the State of New Jersey shall immediately cancel this policy, and the company will return on demand the unearned premium due on account of such cancellation."

In the county society, as already stated, delinquent members are sometimes carried on membership rolls for two or three years after they have failed to pay their dues. The state society does not deal with the individual doctors; and as long as the county society pays the assessment for these delinquent members, they remain in good standing in the state society and their insurance will not be affected.

CHRISTOPHER C. BELING,
Chairman.

JOHN C. MCCOY,
ERWIN REISMAN,
EDGAR A. ILL,
WILLIAM J. ARLITZ,

May 1, 1934

EIGHTH ANNUAL REPORT OF THE COMMITTEE ON INSURANCE

By FRANK W. PINNEO, M.D., *Chairman*

To the House of Delegates:

This Report is for year ending April 18, 1934. The new advantages reported a year ago have been maintained with very manifest satisfaction to the policy-holders. (1) Indemnity for sickness not house-confining, six weeks instead of four, and, (2) liberal inter-

pretation of total disability which may be not strictly "house-confining". These two items have served to abolish questions of interpretation about "total disability". The added coverage including travel by aviation without additional premiums also continues.

A new feature has now been incorporated

in the contract to answer a demand for larger benefits, which was considered by the committee at the convention a year ago and adopted. This provides for weekly benefits of \$75 or \$100 (accidental death benefit remaining the same) at corresponding premiums, application for which, however, requiring more answers than our otherwise brief statement by the applicant.

Another demand is for premium by instalments; and although this increases the risk of the company we expect to meet it by semi-annual and even quarterly payments.

The members now carrying our Accident and Health policy number 249, distributed among 21 counties as follows:

Accident and Health

Atlantic County	7
Bergen	17
Burlington	5
Camden	12
Cumberland	4
Cape May	4
Essex	79
Gloucester	6
Hudson	29
Hunterdon	5
Mercer	10
Middlesex	6
Monmouth	4
Morris	11
Ocean	2
Passaic	13
Salem	3
Somerset	6
Sussex	2
Union	21
Warren	3
— 249	

Policyholders distributed by age groups:

Ages under 50	131
Ages 50 to 60	72
Ages over 60	46
— 249	

Number (and amounts) to whom benefits were paid during the year:

Ages under 50	15 claimants	\$2,654.27
Ages 50 to 60	6 claimants	1,017.85
Ages over 60	5 claimants	1,117.84
		\$4,789.96

These claims ranged from 3 days for \$21.43 to 11 weeks for \$550 on account, the latter being one of 12 uncompleted disability.

Total premiums paid\$16,577.80
Loss Ratio, 29% (which, however, will be greater by settlement of the 12 uncompleted disabilities.)

The Accident and Health policy is written by the National Casualty Company of Detroit,

which has now carried us for one year with success which is further substantiated by their past record and financial reliability as vouchsafed by the Department of Banking and Insurance of the State of Michigan, and also that of New Jersey, and the regular and special reports of the Alfred M. Best Company, a neutral company which functions for insurance like Dun or Bradstreet for business.

The agent is the Blanksteen Agency, Jersey City, which has done excellent service for our members and always manifests genuine interest in their needs. Your committee keeps in constant touch with their correspondence with members.

This year, to answer definite requests for coverage for larger weekly indemnity, provision is now made for indemnities for \$75 and even \$100 weekly at corresponding rates. Another feature, to make payment of premiums easier, is the provision for semi-annual premiums, all of which is shown in the following table:

Age	Annual	Semi-annual
Up to 50	\$60.00	\$31.20
51 to 60	70.00	36.40
61 and over ..	85.00	44.20

Table of premium rates for a weekly indemnity policy of \$50, during disability, and a payment of \$5,000 in case of accidental death. The rates for weekly indemnities of \$75 and \$100 are in proportion to the amounts shown.

These modifications of the policy are to suit different applicants: some want larger coverage to \$100 weekly at corresponding cost, some prefer less coverage at lower cost, some choosing semi-annual payments. We recommend the basic policy for \$50 weekly which covers \$5000 for accidental death, doubled for travel-accident death, and applies to all our members in good standing at any age.

AUTOMOBILE INSURANCE

Number of members carrying	1933	1934
Automobile Insurance	533	953

Every County in the State is represented in the list.

Total premiums paid for one year	\$30,485.04
Earned premiums for one year	15,242.52
Losses paid, Liability and Property Damage, Fire and Theft	2,294.98
Loss Ratio, approximately 10%.	

The work of the year has been characterized by a new agreement whereby the Way Agency offers a feature of unusual character which is to handle cases of accident in which

a member not being liable has claim against the other party. The Agency's care of the case includes investigations, seeing witnesses, recording all the circumstances, and negotiating settlement, even to the extent of furnishing lawyer and taking to court, all being furnished without expense for our policy holder and accounting to him for whatever is recovered. The great advantage to our members is seen in 11 cases during the year, the amounts recovered ranging in each case from \$3.50 to \$133 and amounting to \$336.69. Beside these there are eight similar cases of claims without liability of our member pending settlement, or in process of suit. This means that payment of claims against others have been recovered for them by the agency, which would never have been recovered by the doctor, or only by his lawyer at expenses vastly in excess of the damage claimed and obviating annoyance and expense. One case, for a small amount, which a national automobile association failed to collect in six months, when given to our agency was collected and paid to the doctor in three

days. The letters of appreciation and approval of the service rendered by our agency are numerous and even enthusiastic.

In conclusion this report on *Insurance*, the committee is glad to assure the members of the society that in reliability, financial security and service rendered, the companies and the agents have rendered great and valuable service; and that the premiums paid have been remarkably low and have defied competition, while holding to maximum advantages in coverage. The progress of the year has been excellent in the wider support of the members to which we call attention because increased advantages in our contracts depend largely on the support of the members as reason for such advantages.

FRANK W. PINNEO, *Chairman*
BARCLAY S. FUHRMAN,
WAYNE W. HALL,
EDMUND N. HUFF,
A. DUNBAR HUTCHINSON,
WARREN D. ROBBINS,
CHESTER I. ULMER,

May 1, 1934

REPORT OF THE COMMITTEE ON HOSPITALS AND MEDICAL EDUCATION

By HARRY H. SATCHWELL, M.D.

To the House of Delegates:

Two meetings of the whole committee were held, one on July 9, 1933, and the other on April 11, 1934. At the first meeting it was decided that the committee be divided into two sub-committees, one on Education with Dr. Harry H. Satchwell as chairman, and the other on Hospitals with Dr. Charles Kelley as chairman. The report of this committee for 1932-33 on "The Hospital Standards for Licensure of Hospitals by the Department of Institutions and Agencies" and "Definitions and Standards as a Basis for the Determina-

tion of the Relationship of the Members of Society to Hospitals, Clinics and Dispensaries" was referred to the Sub-Committee on Hospitals for further study in accordance with the action of the Trustees of the New Jersey State Medical Society at their meeting at Atlantic City on June 6, 1933. The committee met again on April 11, 1934, and accepted the reports of the sub-committees. These reports are submitted herewith as Parts One and Two of the report of the full committee.

HARRY H. SATCHWELL, *Chairman*.
May 1, 1934

Part One—Medical Education

By HARRY H. SATCHWELL, M.D.

The members of the sub-committee are: Dr. H. H. Satchwell, chairman; Drs. Carlisle, Smith, Hawkes, Little, Renner, Pyle, deT. Shivers and Brooke. At its first meeting, the following decisions were reached:

1. That lecture courses be given in the various centers established in previous years and along lines determined by this committee in coöperation with the Extension Division of Rutgers University.

2. After a report of the Chairman of conferences between him and Professor Miller, Director of the Extension Division, it was decided that the courses would consist of six lectures each and that the fee for the first and subsequent courses be fixed at \$10.

3. That the fee paid to each lecturer would be \$25 in addition to traveling expenses.

4. That a minimum quota of registrations

for each county group be set at twenty-five subscriptions.

5. That in the larger counties the County Committees would be allowed to retain all income over \$35; this excess to be used for educational purposes such as other lectures than those given in the State Society program or rebating of subscription fees.

6. That the chairman be authorized to set up lecture courses for the dental and nursing professions in coöperation with the Extension Department of Rutgers should such courses be requested by the members of those professions.

POST-GRADUATE COURSES

As shown in the chart which is part of the chairman's report, courses have been or will be given in ten centers. No courses will be given in four centers in which courses were given last year. Two county committees make no reply to suggestions that courses be given. One county committee is undecided at this time but will probably request one course. One committee reports that the financial situation of the members of that county will preclude the possibility of giving a course this year.

The courses given this year are in Surgery, Medicine, Ophthalmology, Neurology, Pathology and Applied Physiology.

A survey to identify the men who have taken the courses during the past four years shows that 1114 members of the State Society, or 40.5 per cent of its membership, have been reached at some time and that 1000 or 89 per cent of the group have repeated their enrollments at some time during the four-year period.

The Sub-Committee has decided that the program next year will be enlarged to include clinical demonstrations of the lectures, laboratory courses in microscopic and gross pathology and clinical pathology, and to offer some bedside teaching to small groups in the hospitals of Essex County. This latter type of teaching will be an experiment.

The statistical reports submitted at this time are of course approximated since the year's work will not be completed until the last week in May. A complete detailed report together with a comparative report of the five years' work will be submitted in time for presentation at the annual meeting of the State Society in June.

ENROLLMENT 1933-1934

Atlantic City	Started Feb. 28, 1 course	34
Bridgeton	Starts April 26, 1 course— Estimated	25
Camden	Starts April 25, 1 course— Estimated	70
Elizabeth	No reply	
Hackensack	1 course	41
Jersey City	Starts April 27, 1 course— Estimated	70
Mt. Holly	Starts April 18, 1 course— Estimated	25
Newark	5 courses—Estimated	250
New Brunswick & Perth Amboy	Started March 29, 1 course— Estimated	27
Newton	Not decided	
Paterson	No reply	
Somerville	Starts April 25, 1 course— Estimated	25
Trenton	Starts April 24 and 26, 2 courses—Estimated	70
Washington	No courses—financial situa- tion	
Estimated total		637

REGISTRATIONS

1929-1930	415
1930-1931	381
1931-1932	322
1932-1933	486
1933-1934	637

ENROLLMENT TO 1933

Total enrollments.....	2104	
Initial enrollments.....	1114	or 40.5% of Society membership
Repeat enrollments....	1000	or 89% 1st enrollments
N. J. Society members..	2750	

POST-GRADUATE MEDICAL PROGRAM

Academic Year—1933-1934

FINANCIAL REPORT

Estimated Field Income:	
5 Newark Classes @ \$350	\$1750.00
1 Hackensack Class @ \$350	350.00
1 Atlantic City Class @ \$260	260.00
1 New Brunswick and Perth Amboy Class @ \$260	260.00
1 Mt. Holly Class @ \$250	250.00
2 Trenton Classes @ \$250	500.00
1 Camden Class @ \$350	350.00
1 Bridgeton Class @ \$250	250.00
1 Jersey City Class @ \$350	350.00
1 Somerville Class @ \$250	250.00
<hr/>	
\$4570.00	

Estimated Direct Field Expenses:

90 Lectures @ \$25	\$2250.00
Travel Expenses of Lecturers	630.00
Printing and Mimeographing	366.14
Stenographic Service, Travel Expenses, and Telephone Expenses of University Technical Advisor	200.00
Travel Expenses of University Extension Staff	453.86
University Telephone and Postage	310.00
One-third Time of Stenographer	360.00
	<hr/>
	\$4570.00

COLLATERAL ACTIVITIES

1. At the request of the Essex County Medical Society in its immunization campaign, this committee through the Essex County Committee on Education arranged and presented a lecture by Dr. Bela Schick on diphtheria immunization on March 19, followed on March 22 by a demonstration of the technic of testing and immunization given by members of the Essex County Society. Both these meetings were attended by about three hundred.

2. In coöperation with the Bergen County Medical Society, this committee presented a course of lectures on heart, lung, communicable diseases and periodic health examinations jointly with the Bergen County Tuberculosis League. The Tuberculosis League advanced \$200 to the Bergen County Committee. This was used to pay partly for the course and the members of the County Society subscribing to the courses were in that way privileged to subscribe at three dollars.

3. In view of the fact that heart disease is the largest single cause of death and that nothing was being done in the way of care or welfare of the indigent cardiac, this committee through its chairman recommended to the President of the Essex County Medical Society, Dr. Edward Sprague, that a committee be appointed to study the problem. Such a committee was appointed and the Chairman was appointed a member. Based on its report, the Essex County Society authorized the organization of a Heart Commission. This was formed on March 26 and consists only of members of the Society. The Chairman of the committee was elected Secretary and Chairman of the Clinic Committee for the purpose of organizing an educational program in the study of heart disease for the medical men working in the six cardiac clinics in Essex County. These to hold monthly round tables

with some member of the faculty of one of the medical schools as guest.

4. Without intending to operate a placement bureau this committee has in the last year placed at their request six men in the clinics of the New York hospitals for a limited time and also one in July, 1933, for a one-month stay in the Joslin Clinic in Boston. Also it has placed as post-graduate students in surgery two men in 1932, one to start in September, 1934. These have become regular students in surgical courses given by the New York University Medical College in its college and in its surgical division in Bellevue Hospital.

RECOMMENDATIONS

1. That inasmuch as the demand and the need for continued training and education of nurses along Post-Graduate lines exists, it is recommended to the Trustees of the State Society that they recommend to the University Extension Division of Rutgers University that post-graduate courses in medical subjects for nurses be instituted and that these courses be given by this committee in coöperation with the Extension Division.

2. That since heart disease is now the largest single cause of death and that since there is nothing, or at least nothing adequate, being done in the way of care and prevention of heart disease, and that since a large part of any such activity will consist of the education of the doctor and the patient, this committee recommends to the Trustees of the State Society that they grant it the privilege of considering itself a committee appointed to study and correlate the problems related to the care and prevention of heart disease and that it be allowed to report its findings and recommendations as soon as such a study has been made.

3. It is recommended that the Committee on Hospitals and Medical Education be enlarged to include one man from each county who has been interested and active in the post-graduate teaching program. The purpose of this recommendation is to have men on the committee who will be contacts with the county societies so that the teaching program each year can start in the fall. In the past the contact of the State Committee with each county society has been through a committee on post-graduate education which is usually appointed so late in the year that the State Committee is unable to start its activities until after January first.

Part Two—Hospitals

By CHARLES B. KELLEY, M.D.

That part of the report of the *Committee on Hospitals and Medical Education* relating to hospitals, which was submitted at the Annual Meeting at Atlantic City in 1933, was referred back to that committee for further consideration of certain parts which required clarification. (That part of the report relating to hospitals was printed in *The Journal* of May, 1933, pages 386-390. The recommendation of the Committee on Hospitals and Medical Education relating to hospital and staff regulations was printed on pages 35 and 39 of the Official Transactions of the 1933 meeting.)

The report on hospitals was considered by the Trustees on June 7, 1933, and was resub-

mitted to the Committee on Hospitals and Medical Education for further study. It was resolved that, on the re-submission to the Board of Trustees of these revised provisions and their approval by the Board, the recommendations were to become effective.

The Committee on Hospitals and Medical Education has submitted its report to the Board of Trustees and has made certain changes to meet the objections contained in the earlier draft. However, the Board of Trustees wishes to consider carefully the provisions of this report before their adoption.

May 1, 1934.

REPORT OF THE WELFARE COMMITTEE

By FREDERIC J. QUIGLEY

To the House of Delegates:

The report of the Welfare Committee is presented in the subjoined reports of the Sub-Committees on Legislation, on Medical Practice, on Workmen's Compensation, and on a

Uniform Medical Practice Act. All these reports were approved at a regular meeting of the Welfare Committee, April 15, 1934.

FREDERIC J. QUIGLEY,

May 1, 1934

Chairman.

REPORT OF THE SUB-COMMITTEE ON LEGISLATION

D. LEO HAGGERTY, M.D., *Chairman*

To the Welfare Committee:

The Committee on Legislation is a Sub-Committee of the Welfare Committee and functions during the period when the Legislature is in session. Its plan of action was outlined in *The Journal* of February, 1934, page 107, and has been followed with excellent results. The plan in briefest outline was as follows:

1. The Executive Secretary shall be the Executive Officer of the Committee.

2. The Executive Secretary shall ascertain the attitude of each Legislator toward each bill and explain the reasons why the doctors support or oppose it. The Executive Secretary shall follow the course of each bill, and act as a source of information to the physicians and to the Legislators.

3. The facilities of the Executive Offices of the State Society shall be used for correspondence and the distribution of bulletins and circulars of information.

4. Each county society shall form a Leg-

islative Committee with which the Executive Secretary shall keep in close touch through the key men.

5. Key men shall be selected in each county society for the purpose of getting in touch with the local Senator and Assemblyman, upon the request of the State Committee; and of informing the State Committee of the attitude of the legislators on each bill.

Fifty-three bills of interest to the medical profession were introduced in the Legislature.

Analyses of the salient points of selected bills were prepared and issued for the benefit of the members of the Welfare Committee; and copies of the analyses were sent to the component county societies. Legislative bulletins were issued periodically announcing bills of special interest to members of the State Society as soon as they were introduced.

The prompt action and effective work of the key men have been gratifying to the Welfare Committee; and the information which they

have given to their local representatives has been appreciated by the Legislators.

STATUS OF BILLS, MAY 3, 1934

One of the most important measures sponsored this year was S-136. This bill was an amendment to the *Hospital Lien Act*, and was drafted by a sub-committee of the Welfare Committee, composed of Drs. Sewall, Dandois and Green. It was introduced by Senator Reeves of Mercer County, and was amended in the *Committee on Revision and Amendment of Laws*, of which Senator Leap is chairman, in order to meet objections raised by the New Jersey Bar Association. This amendment was accepted by the sub-committee, and was incorporated in the bill. This measure has been passed by the Senate and the Assembly. The new law will be of distinct benefit to the physicians of New Jersey.

S-183, known as the *Doctors' Title Bill*, was introduced by Senator Woodruff after its approval by the Welfare Committee. It had been found impossible to formulate a satisfactory *Uniform Medical Practice Bill* in time for its introduction in this session of the Legislature owing to the vast number of laws and precedents to be studied. The sole purpose of the Doctor's Title Bill is "to limit the use of the title 'Doctor' by those treating human diseases to Doctors of Medicine and Doctors of Dental Surgery". (Editorial, April Journal, page 188.) This bill has already been of great value in counteracting the efforts of cultists to pass their pet measures. The cultists all united in its opposition, thus proving that the title "Doctor" is cherished highly by them as an asset of financial value.

S-73, known as the *Osteopathic Bill*, was introduced by Senator Prall, and is still in the Judiciary Committee. It would broaden the scope of practice by Osteopaths so that they would be permitted to engage in almost every form of the practice of medicine and surgery, except the performance of cesarian sections. The bill has not been reported out of committee.

S-207 would give a regular license to a limited licensee without any study in a medical school, provided he has been associated with a regularly licensed physician for five years. This bill is said to be designed to be for the benefit of only one individual. It is a vicious piece of legislation, and is still in committee.

A-303 is a combination cult bill setting up a board of examiners for osteopaths, chiropractors, and naturopaths. It is still held in committee.

A-22, known as the *beautitians' bill*, passed the Assembly in the closing hours before adjournment. This bill should be changed in the

Senate to provide for supervision of the "beautitians" by the State Board of Health according to a code to be formulated by the Board.

Bills A-4, 5, and 6, introduced by Dr. Newcomb, Assemblyman, and relating to the examinations of the chests of school teachers and pupils, were endorsed by the Welfare Committee. A-4 and 6 have already passed the Assembly, and they are now in the *Education Committee* of the Senate, and should be supported.

A-256, providing for a fee of ten dollars for the examination of an automobile driver arrested on a charge of drunkenness, was defeated in the Assembly. The charges of five to twenty dollars still stand as provided in the present law.

A-313, to extend the exemption of professional boards from the Budget Act, has passed the Assembly, and is now in the Judiciary Committee of the Senate. It should receive the united support of the members of the medical societies. S-186 should be amended to provide for a similar exemption.

A-176, 177, 194, 314; S-158 and 184, measures introduced regarding Workmen's Compensation, were not pressed owing to the fact that a committee appointed by the Governor to make a new Workmen's Compensation Act, or alterations to the present Act, has not completed its work.

A-255, providing for the care and control of carriers of disease, and A-373, and appropriating emergency appropriation of \$10,000 for toxoid to be used in the prevention of diphtheria, have been sponsored by this committee.

A-132, introduced by the school physicians to allow them to participate in E. R. A. funds, was introduced without the knowledge of the Welfare Committee; but after its introduction it was pushed by our committee, finally becoming a law. Then it was found that the law which it amended was superseded by S-42, which had the same objectionable features. Through the coöperation of Dr. Quigley and the Emergency Relief Administration, Senator Wolber introduced S-251, which has now become a law. This experience is evidence that all medical legislation should be introduced through the Welfare Committee.

Our committee has functioned well during the year. It is recommended that, in the coming year, a special committee be appointed to analyze all bills. The analysis of bills, as handled this year through groups of three, did not prove adequate, because of the danger that many an innocent looking bill having objectionable features might not be readily recognized by those with limited experience.

D. LEO HARGERTY, M.D., *Chairman*.
April 15, 1934

REPORT OF THE SUB-COMMITTEE ON MEDICAL PRACTICE

By THOMAS K. LEWIS, M.D., Chairman

To the Welfare Committee:

The Committee on Medical Practice has made extensive studies which will be reported at the General Session of the Medical Society of New Jersey on the evening of June 5th. However, the committee submits an abstract of its findings and recommendations for consideration by the House of Delegates.

PART 1—DISPENSARIES

The abuses and evils of dispensaries may be summarized as follows:—

(1) Lack of proper and adequate investigation of the economic status of patients admitted for free treatment. (In some cases no investigation.)

(2) Carte blanche to the proteges of school nurses, field workers of various organizations, social unlifters, and influential employers without any investigation whatsoever.

(3) The absence of any standard interpretation of the meaning of the word indigency.

(4) An over zealous social service that has departed from its original function of assisting the physician, and has assumed a paternalistic attitude toward applicants for treatment.

(5) Medical service de luxe offered on a silver platter to the poor and semi-poor so that a certain stratum of society has learned to prefer dispensary service to that offered in the office of private physicians.

(6) The prevalence of the belief among the laity that dispensary service is available to anyone whether able to pay or not.

(7) Lack of any effort at control of admission to fit the capacity of staff of the dispensaries.

(8) Lack of mutual sympathetic understanding between the dispensary physicians and board of managers, resulting from the absence of official contact.

(9) The development of many clinics as adjuncts to public health departments, such as baby saving clinics, prenatal clinics, immunization clinics, and health camps. Because these agencies are provided for by public funds, no one is excluded.

(10) There are a few instances of lay-controlled clinics that actively solicit patients in open competition with the medical profession.

Obviously reforms are necessary. Many of these reforms must begin with the physician himself. Patients must be taught by practical experience that a service just as ade-

quate can be obtained in the physicians' office, as in the hospital dispensary, and upon a There is no reason for avoiding simple laboratory measures such as urinalysis and blood much more personal and sympathetic basis. counts in ordinary office practice. The physician should be ready at all times to administer prophylactic measures such as diphtheria toxoid and smallpox vaccination. He should be prepared to give periodic health examinations, and should show an active interest in all phases of preventive medicine. It should not be forgotten that our woeful neglect of these matters has had much to do with the establishment of the numerous clinics by health and school authorities, and with the growth of diagnostic clinics and life extension services, so much in vogue.

STANDARDS

A standard form of dispensary set-up and management should be adopted by the Medical Society of New Jersey. The following plan is recommended:—

(1) Patients to appear at a definite time convenient to the physician who is donating his services.

(2) Control of the dispensaries to be vested in a staff committee of three members.

(3) It must be recognized that the dispensary is a charity, and that it must be supported by charitable donations, with the physician giving his time and the philanthropic individual his money. The patient should be able to give nothing beyond the merest pitance.

(4) The personnel to be composed of:

- a. Physicians qualified in their particular branch.
- b. Nurses whose entire duty is in the dispensary.
- c. Clerks trained in handling patients and records.
- d. Registrars who understand the various dispensaries and can elicit information from applicants for treatment.

(5) The patient should be one who cannot afford adequate medical care. By this we mean a patient who does not have means to consult a physician in general practice, and be cared for or directed by him. Requirement for admission, except for first treatment in emergencies, should be a note from the family physician stating that the patient is worthy of free treatment. The enforcement

of this rule immediately solves the problem of dispensary abuse by non-charity patients.

(6) The social service should be so organized that the physician's instructions are carried out as he desires; and it should serve no other purpose. It should be directly under the control of the staff committee, or the medical director.

(7) The pharmacy to compound and dispense only official drugs. All drugs to be dispensed without cost to the patient.

(8) The admission clerk to be a tactful individual who directs each applicant to his family physician, or to the dispensary according to his conditions and means.

PART 2—CONTRACT PRACTICE

Whether we approve of it in principle or not, contract practice is here as a permanent fixture. Many factors conspire in making its presence an unavoidable necessity. In a government that grows increasingly bureaucratic, the various state, county, and municipal medical positions, if conducted on a fee basis, would become cumbersome, unwieldy, and inefficient. Red tape, shifting of responsibility, and political interference would be increased. Without doubt many of these jobs can be more economically and efficiently handled on the contract basis. In the field of industry contract practice has come into being as a result of necessity. The Workmen's Compensation Act, while favorably effecting the laborer, has put the employer "on the spot," and has forced him to protect himself by way of insurance. The insurance companies make certain demands of the employer along the lines of medical care and protection. Also certain industries are of such a nature as to entail physical danger to the workmen to an extent that renders ineprative the presence of immediately available medical aid. All these factors, briefly alluded to, render contract practice unavoidable and justifiable in industry. Such practice properly regulated need have no objectionable features, and should result in mutual good to all parties involved. It remains for the medical profession to stand firmly for those principles which when applied, will ensure satisfactory contract practice, and thus adapt itself to a new phase of the practice of medicine.

PRINCIPLES OF CONTRACT PRACTICE

Those principles that will be productive of soundly ethical contract practice, are listed as follows:—

(1) The physician upon entering into a contract will have a detailed written agree-

ment as to the duties, scope of activity and responsibilities of the position, together with a clear understanding as to the limitation of his activities in order that he may not be called upon for unethical procedures.

(2) The duties and the salary shall be such as to uphold the dignity of the profession and render worth while a high grade type of medical care.

(3) Competitive under-bidding with other physicians should not be countenanced.

(4) The details of the proposed contract should be discussed with and approved by the board of censors of the component medical county societies.

(5) Appointments of physicians to state or municipal positions should receive the approval of the state or county medical society concerned.

(6) Broadly, the duties of the contract surgeon should be limited to:

- a. The examination of applicant for employment.
- b. The treatment of surgical and medical emergencies arising while the employee is on the property of or executing the orders of his employer.
- c. The supervision of such hygienic and sanitary measures as will contribute to the welfare of the employees; and,
- d. Advisory capacity to the employer for determining whether medical or surgical care being administered to an employee by outside physicians is adequate.

(7) Free choice of physician by the employee should in no way be interfered with, except that the request for consultation should be permissible.

(8) There should be no solicitation of patients.

(9) There should be no competition in any way with the physician in general practice, either by medical treatment of an employee beyond the immediate emergency, or the treatment of any member of the employees family.

SCHOOL MEDICAL SERVICE

The trend of *school medical service* has been gradually extending itself beyond its normal function, that of caring for the health of the *child in school*, to the point of assuming responsibility for the health of the *school child*.

We recommend for the immediate future that the New Jersey State Medical Society embark upon the following activities:

- (1) The adoption of a code for standardization and regulation of contract practice.
- (2) The instruction of our members, par-

ticularly the younger men, in the ideals of ethical practice; and the encouragement of our members to consult with and accept the advice of the boards of censors of the respective component societies when contemplating the acceptance of any contract position.

(3) The institution of a campaign for modification of school medical service, either toward limitation of present activities or for their more thorough execution.

(4) That a concerted and sustained effort

be made to remove state and municipal medical positions from political control, and to procure for these positions adequate remuneration.

THOMAS K. LEWIS, *Chairman*
ANDERSON A. LAWTON,
CHESTER I. ULMER,
H. B. WILSON.
E. LE ROY WOOD

April 15, 1934

REPORT OF THE SUB-COMMITTEE ON WORKMEN'S COMPENSATION

By DAVID A. KRAKER, M.D.

To the Welfare Committee:

The Sub-Committee on the Workmen's Compensation Act held its first meeting after its appointment in September, at which time a conference was held with the Medical Directors' Committee of the National Bureau of Casualty and Surety Underwriters, with the idea in mind of developing improvements in the operation of the act by mutual agreement between the National Bureau of Casualty and Surety Underwriters and the State Medical Society. At this meeting, this committee presented to the Medical Directors Committee of the National Bureau a plan for them to discontinue the practice of medicine by the carrier, and to substitute a cooperative plan of consultation in the treatment of compensation injuries or occupational disease. No definite conclusion was reached. The Medical Directors' Committee of the National Bureau appointed a sub-committee which met on two occasions with our committee in Newark, and entered into satisfactory agreements, but up to the present time no action has been taken by the National Bureau.

In October, our committee conferred with the chairman of the Investigating Committee on the Compensation Law, and certain suggestions of this committee were presented to Dr. McBride; and after discussion an appointment was made for this committee to appear before the Legislative Committee. At the first appearance of this committee before the Legislative Committee in November, the general conditions in the Compensation Bureau were discussed, but no definite suggestions were made. Regular weekly sessions of this committee were held and several visits were made to the Compensation Courts and the Rehabili-

tation Clinic in Newark; and the recommendations which were later presented to the Legislative Committee were finally adopted by this committee.

On January 8, 1934, the committee presented to the Legislative Committee in formal hearing these recommendations, copies of which have been in the hands of the members of the Welfare Committee since that time.

Since this presentation, the Chairman has discussed this report with several members of the State Judiciary, and an attempt has been made to arrange a conference with the newly appointed Commissioner of Labor, Mr. Toohey, at the suggestion of one of the Vice-Chancellors, who himself has had considerable experience in adjudicating appeals from the Compensation Bureau to the Common Pleas Court, of which he was for many years a member. No official information has been received as to the inclusion in these recommendations by the Legislative Committee of this committee's recommendations. The Secretary of the Legislative Committee, in an interview with the chairman of this committee, assured him that his committee would make a very close study of all of the evidence as presented at the hearings, but gave no assurance of the inclusion of these recommendations.

Our policy is one of waiting until the report of the Legislative Committee has been made to the Legislature. It is recommended by the committee that legislation along the lines of this committee's recommendations be prepared and introduced in the event that the Legislative Committee does not include our committee's plan in some concrete form in their final recommendations.

THE COMPENSATION LAW IN RELATION TO THE PHYSICIAN

The Compensation Law of New Jersey under which, by Legislative Act, the employer is responsible for the payment of compensation for injury or disease contracted during employment, was originally passed in 1911. It has been amended on several occasions so as to clarify the administration of the Act and, also, for the purpose of not only curing the disabled, but aiding in the prevention of accidents or occupational disease in industry.

The Act now provides that the employer shall furnish such medical, surgical and hospital services as are necessary to cure and relieve the injured workman of the effects of the injury, and to restore function to an organ or limb wherever restoration is possible. This obligation, without being specifically stated in the Act, has given the right of selection to the employer, or to his agent, the carrier.

The carrier's basic opposition to the employee's right of selection is the presumption that the average general practitioner is not competent to treat injuries or disease occurring in the course of one's employment. The carrier contends further that the cost of a given case, when treated by the physician in general practice is increased beyond the costs of the treatment rendered by the physician engaged by them. It is quite apparent that the latter contention is the more important one in their estimation, but is not generally true in practice.

The argument that one must be a traumatic surgeon to treat these cases is as untrue in actual experience as the presumption that a surgeon, to treat battle casualties, must be a specialist in military surgery. The records of the War Department at Washington show that the number of qualified military surgeons available in the United States at the outbreak of the war was so small as to make the whole contention ridiculous. It is, further, quite evident to the medical profession that the title "Traumatic Surgeon" is one that is generally associated with practitioners in the Compensation Bureau. It does not signify, as in other specialties, long and continued preparation and experience in a particularly limited field of surgery.

The committee recommends, as a solution to this problem (1) that the employer or carrier discontinue the treatment of compensation injuries or occupational diseases, and substitute a coöperative medical supervision; (2) that the employee have the right to select his physician and that the carrier select practitioners of medical standing and experience, who,

when a case is reported to the carrier, will arrange for consultation with the attending physician and advise with him as to treatment. If, in a given case, opinions differ as to the advisability of transferring a patient to the care of a specialist, or where there is a dispute upon other elements of treatment, or when no satisfactory agreement can be reached, it is suggested that these matters be referred for settlement to the state examining physician in the district.

The Workmen's Compensation Act as originally passed provided only for informal hearings presided over by a referee. The fact that the referee is called upon to make a decision based entirely upon the medical evidence necessarily created the demand for the appointment of a medical advisor or referee for the state. It is his function to examine the petitioner in the presence of the attending physician and the carrier's doctor, and render an opinion as to the amount of disability existing. The referee bases his determination upon this opinion, but no stenographic record is made of the procedure. The only report is that of the state physician made in writing to the referee. The informality of these hearings and the lack of stenographic records have created much dissatisfaction and considerable publicity. It is hoped that the Legislative Committee now investigating the Compensation Law will recommend the improvement of this procedure and the elimination of unsatisfactory conditions.

The amendment to the Act in 1918 provided for the appointment of Deputy Commissioners of Labor, whose function it is to preside at formal hearings. This created a judicial tribunal with a definite judicial procedure. The Deputy Commissioners act upon an application by either party for a final determination of permanent physical disability.

There is only one legal proposition entering into any of these claims, and that is whether the injury occurred in the course of the man's employment. All other questions are entirely medical. The petitioner is represented by counsel, who supports his application upon the testimony of the attending physician plus several opinion witnesses. Necessarily, this requires testimony of a similar character by medical men for the defense. The Deputy Commissioner, after hearing this testimony, is expected to make a decision based upon this evidence.

It must be apparent, after study of this Act, that an opinion by a counselor-at-law, upon a medical question, without fundamental knowledge on his part, can only be in the manner of a compromise. In the opinion of the com-

mittee, such adjudication should be determined by medical men rather than by lawyers. As a result of the elaborated procedure of the formal hearings and the great amount of medical testimony presented, there has been much unfavorable criticism of the medical profession. It must be quite clear that the need for this testimony is created by the contentions raised by the several attorneys who represent the parties in suit; the legal profession, therefore, should receive its fair share of criticism.

The committee recommends as a remedy for these apparent judicial defects, that the law be amended to provide for a complete separation of the legal from the medical questions pertaining to the determination of disability claims.

(1) That a date be set for the primary hearing to consider the legal questions involved, presided over by a Deputy Commissioner, who shall take such testimony as is necessary and which shall be stenographically recorded. During the period coincident with the primary hearing, the State Examining Physician shall examine the petitioner after having an opportunity to study the record of the case as rendered by the attending physician, and shall render a determination as to the disability involved, which shall constitute the medical evidence in this primary hearing. This report shall be forwarded to the Commissioner of Labor, and shall be part of the record of this primary hearing. The employer or carrier may be represented by his physician at the primary medical hearing and he may be consulted by the state physician. All the proceedings at this primary medical examination shall be recorded stenographically and, as before stated, be the medical evidence in the particular case. It is believed that with this method the majority of the cases will be disposed of at these primary hearings.

(2) (a) If there is a dispute as to the claim for physical disability from the determination by the State Examining Physician and report to the Commissioner at the primary hearing, an appeal may be taken based upon this record to the Medical Board of Referees, consisting of five physicians licensed to practice medicine and surgery in the State of New Jersey, appointed by the Commissioner of Labor upon the recommendation of the Medical Society of New Jersey.

(b) This board will hold hearings at designated times and places, will hear the statement of the attending physician and such consultants as were associated in the treatment of the petitioner, including a complete history

of the case with laboratory findings both clinical and roentgenological as are at hand, and the statement of the carrier's physician and consultants, who have examined and who were concerned in the treatment of the case, with such laboratory findings both clinical and roentgenological as they may have of the petitioner's case.

(c) At the conclusion of this hearing, the board will make a complete examination of the petitioner and render an opinion and report with a determination of this disability, which shall constitute the medical evidence in the case, to the Commissioner of Labor. These hearings shall be stenographically reported, the hearing shall be open to the members of the medical profession, except during the examination of the petitioner by the board.

(3) Appointment.

(a) The State Physician shall be appointed by the Commissioner of Labor upon the recommendation of the State Medical Society, of physicians licensed to practice medicine and surgery in this State of New Jersey. He shall devote his entire time to the work and have not other practice during his term of office. The term of his office shall be permanent, and he can only be removed for cause after a hearing by the Commissioner of Labor, and he shall receive adequate compensation.

(b) The Medical Board of Referees shall be appointed by the Commissioner of Labor upon the recommendation of the State Medical Society. Its members shall be physicians licensed to practice medicine and surgery in the State of New Jersey, of standing and experience, and shall devote their entire time to the work, shall have no other practice; the terms of office shall be permanent, and they can only be removed for cause after a hearing by the Commissioner of Labor; and they shall receive adequate compensation.

(c) This board shall consist of five members, at least three of whom shall be present at each hearing; and to the board shall be referred all medical matters in dispute.

(d) This board shall hear appeals from the primary hearings, as a board of appeal.

(e) It shall consider and determine all disputed claims relating to medical bills.

(f) The State Physician in each district shall act as arbitrator upon questions concerning disputes between the medical practitioners and the examining physician for the employer or carrier and render an opinion. If disagreement still exists, appeal may be taken to the Medical Board of Referees.

(g) The Medical Board of Referees and

the State Physicians, all of whom shall constitute the Medical Board of the Compensation Bureau, shall study all questions concerning occupational diseases and their prevention and report on them to the Commissioner of Labor.

(h) The Medical Board of Referees as well as the State Examining Physicians, shall render an annual report to the Commissioner of Labor, of all hearings, and other work accomplished, during the year, which shall be published and distributed to the medical and legal professions and all others concerned.

The Sub-Committee on Compensation of the Welfare Committee urges the several component societies to cooperate in the study of those recommendations, and to give their collective aid to the Welfare Committee and the State Society in order to obtain such changes in the procedure and administration of the Compensation Bureau as will make possible the improvements outlined.

A summation of the work of this committee up to the present time includes such preliminary reports as have already been made to the Welfare Committee and are part of its record. The recommendations provide for the right of selection of his physician by the employee and recommends the discontinuance of treatment of compensation cases by the carrier, and the substitution of a physician who shall act as consultant in the treatment of the injured employee if a disagreement occurs as to treatment or as to question of the transfer of a case to a specialist, the problem is to be referred to the state physician in a district for adjudication. If this adjudication is unsatisfactory, it is then to be referred for final determination to the Medical Board of Referees in the Compensation Bureau. These recommendations provide definitely for the free choice of physician and protect the employer in the fact that he becomes the participant in the treatment of the case. In this manner the petitioner, the employer and the physician are placed in their proper positions.

(a) The committee made recommendations in concrete form to the Legislative Commission, providing for the adjudication of disputed medical claims by state physicians and by medical boards of referees. It was assumed that the Legislative Commission would, in its report to the Legislature, discuss these recom-

mendations as submitted; but up to the present the Commission has made no definite recommendations as to the revision of the law, and has been continued for further study.

(b) The committee has considered the recommendations made by the Governor's Committee on the Compensation Law of the State of New York, which is now embodied in a bill before the New York State Legislature; and approves several of the amendments and hope to have them presented to the Legislative Commission at a future hearing, so as to include some of these procedures in the New Jersey law.

The suggestion was made that this committee introduce a bill in the Legislature embodying its recommendations, but this was not deemed advisable at this time.

The committee's research has demonstrated the need for a close cooperation upon the part of the New Jersey State Medical Society with the Department of Labor and the Bureau of Compensation, in its administration; particularly as it relates to medical affairs. It is recommended that the study of this subject be continued; that this cooperation be made part of the law; that the subject of medical care of the injured employees be definitely defined; that the procedure of adjudication of disputed medical claims in the Bureau of Compensation be determined by practitioners of medicine rather than by lawyers; that the ethical control of medical practices in the Department of Labor and in the Bureau of Compensation be governed by the State Medical Society and its component county societies.

It is further recommended that the committee continue its study as above stated; and that it prepare a bill to be introduced in the next session of the Legislature which will embody the recommendations already made to the Commission, with such other regulating measures as will permanently improve the administrative procedure in the Department of Labor and in the Bureau of Compensation.

DAVID A. KRAKER,
Chairman
WILLIAM H. ARESON
JACK BLUMBERG
E. ROY VAN NISS
EARL LE ROY WOOD

REPORT OF THE SUB-COMMITTEE ON UNIFORM MEDICAL PRACTICE ACT

By SAMUEL ALEXANDER, M.D.,

To the Welfare Committee:

The Committee on Uniform Medical Practice Act, appointed by President Quigley, has held several meetings to consider the subject in its various phases.

At these meetings we have met with a committee appointed by the New Jersey State Board of Medical Examiners, consisting of Drs. Kelley, Liva and McGuire, who have given us valuable assistance and to whom we are deeply indebted for this aid. Mr. Richman, former Assistant Attorney General, has also been of great assistance to us.

The committee's task was to have drawn up a bill that would set up a single standard for all those desiring to take up the practice of medicine and surgery in any of its branches. At the present time, this act would apply to medical doctors, osteopaths, optometrists, chiroprodists and chiropractors.

Your committee finds this subject a very complicated one, and the deeper we go into it the more complex does it appear. It is very difficult to draw an act which is ideal as far as the uniform practice of medicine is concerned, and, at the same time, practical enough to hope to have it passed by the Legislature and signed by the Governor to become a law.

Our information is that at the present time there is no uniform medical practice act in any state of the Union.

RECOMMENDATIONS

The Doctors' Title Bill was drawn up by Mr. Stryker, of Newark, and introduced into the Legislature.

The committee is unable at this time to make its final report. More time and study must be

given to the matter. However, we are able to submit at this time the following for your approval or disapproval:

Two major problems present themselves.

(1) What to do with the osteopath, chiropractor, chiroprapist, or optometrist who desires more privileges than those granted him when licensed by the State Board of Medical Examiners.

Our answer to that is that present licentiatees be continued with the privileges and limitations of the Act under which they are licensed.

(2) What to do with all future matriculants who desire to take up the practice of medicine and surgery in any of its branches.

The committee makes the following recommendations:

(1) Four-year high school course.

(2) Two-year pre-professional course in a college approved by the Commissioner of Education.

(3) Four-year course in a professional school approved by the New Jersey State Board of Medical Examiners granting the degree of M.D., D.O., D. Chir., D. Opt., D.S. Chiro.

(4) One year as interne in a hospital approved by the New Jersey State Board of Medical Examiners, or its equivalent as one-year post-graduate course in a college or hospital approved by said Board of Medical Examiners. The requirements of the intern or post-graduate course to be prescribed and approved by the Board of Medical Examiners.

SAMUEL ALEXANDER, M.D., *Chairman*,

April 15, 1934

REPORT OF THE SPECIAL COMMITTEE ON PUBLIC HEALTH

By STANLEY H. NICHOLS, M.D., *Chairman*,

Asbury Park, N. J.

To the House of Delegates:

One of the two definite projects that were adopted by the House of Delegates on June 6, 1933, was that the medical societies of the state and counties, through their Public Health Committees, should undertake the diphtheria immunization of babies and children between the ages of six months and six years, as the first step in pre-school supervision by the family physician. The object of this work was not only to get diphtheria immunization done, but

also to create the health machinery in the state and county societies which will assume other measures of public health nature, and so will *recover for our physician members their rightful heritage*. Specific progress has been made during the past year.

Our committee has held frequent meetings, and its members have made many addresses and held numerous conferences with the public health committees of the county societies and other health groups, in order to arouse our

members to a knowledge of what we are trying to do, and thus secure their loyal participation in getting this recovery program under way.

District Councilor meetings have been held with the Public Health Committees of each councilor district, at which times the plans and the difficulties met by each county society in getting this plan under way have been discussed. One or two members of our state committee have been assigned to each councilor district and have been of definite service in developing local plans.

The result so far has been that two-thirds of our county societies have become aware of the importance and significance of this recovery program, and have made considerable progress in developing a plan to meet the needs of their individual counties. It is essential that the remaining county societies should join with the health officials and other county health agencies interested in diphtheria immunization and get started on definite programs of work.

Our State Board of Trustees, the Welfare Committee, and many others have assisted our committee in arousing our county societies to participate in our present plan. The chairman of the committee has met with the Board of Trustees, and regularly with the Welfare Committee, taking no important step unless it was first approved by those bodies as to policy. Our committee has also studied such matters of health nature as were referred to it by the State Welfare Committee, and has then recommended appropriate action to the Welfare Committee.

PUBLIC HEALTH HOUR

At the invitation of President Quigley of the State Society, our committee has sponsored the appearance of Commissioner of Health Henry Vaughan, of Detroit, before a special meeting of the State Society at Newark, and also before the Health Section of the New Jersey Conference of Social Work at Asbury Park at its annual meeting, for the purpose of presenting the Vaughan Plan of a "*Public Health Hour*" in the physician's own office, in order to encourage medical participation in various pieces of preventive and public health work, and to replace clinics of the Public Health Department for these purposes. Our committee has recommended to the county societies a plan similar to Vaughan plan of coöperation with the local health departments to be adapted to the needs of each county; and that our members create a *public health hour* in their own offices for the purpose of returning to the physicians's office the entire services in the preventive field of public health, and

thus make individual physicians an efficient aid to health departments and health agencies in each city and county.

The financial possibilities of the development of this public health hour by each physician and county medical society are enormous. If it is properly and carefully developed, each participating physician will be able to restore a considerable part of his income which has been lowered during the depression.

DIPHTHERIA IMMUNIZATIONS

The compilation of the results of the pre-school survey of the state is not yet complete, but the figures of one small part of this state in the national survey of 7000 pre-school children and babies showed that 75 per cent of them had not yet been immunized against diphtheria. The previous accomplishments in diphtheria immunization have been largely among school children. If anything like this ratio obtains in the rest of the state, it would mean there are at least between 200,000 and 300,000 pre-school children in this state who are not immunized against diphtheria. If half of these could be immunized at one dollar per injection during the coming year—and this is not an idle dream if our county societies speed up their present activity—it will mean a total income from this source alone of between \$200,000 and \$300,000, assuming that one-half of the number are indigent and immunized free of charge.

Once our county societies and our individual physicians have instituted an efficient system of giving diphtheria immunizations, other income-producing activities can be added to the physician's public health hour, such as the following:

- (1) Vaccination.

- (2) Supervision of the health of the pre-school child. (A blank already has been prepared by the Public Health Committee for this purpose.)

- (3) Tuberculosis tests, physical examinations, case finding, and follow-up of patients, in conjunction with the Tuberculosis League of the state and counties. (Our state public health committee is now meeting with a special group from the New Jersey Tuberculosis League and working out a plan for the participation of our physician members in their own offices.)

- (4) Periodic health examinations.

These and other possible activities can be made to yield a total income to our membership of between one-half million and a million dollars annually, if they are properly directed, and each member coöperates loyally. In addition, and even more important, we will be

rendering a much needed improvement in medical care and health service to the people.

In January, 1934, the Essex County Medical Society, the largest in the state, announced the following policy:

"(a) Private physicians shall immunize all children against diphtheria.

"(b) Indigents shall be immunized free, the physicians determining who is indigent.

"(c) The physician should provide "a public health hour" (not his regular office hour) at such intervals as he may determine, when he will give immunizations at \$1 per injection.

"(d) For immunizations at other hours the physician shall charge his usual fee.

"(e) Considering the free immunization of indigents and the protection of the public through immunizations, it is expected that toxoid will be supplied to physicians without cost by boards of health for all cases.

"(f) Physicians shall supply to boards of health, on official blanks, such data regarding the immunization as may be required."

Efforts should be made by the public health committees of the county societies to have the boards of health in the several municipalities in each county include in their 1935 budgets reasonable funds for payment to physicians for the immunization of indigents, as well as to provide the toxoid.

The best progress is being made in those counties where the public health committees are most active and the population most concentrated. Bergen, Hudson, Union, Essex, Middlesex, Camden, Burlington, Monmouth, Gloucester and Atlantic Counties have made notable progress toward perfecting their health machinery, and each has an enrollment of from 50 to 600 members agreeing to do this work. Several of the less densely populated and more rural counties are encountering considerable difficulty in getting started, and in these counties the assistance and personnel of

the State Department of Health will prove most valuable.

Twenty county societies have public health committees doing earnest work in promoting the physicians' public health recovery program. They deserve our thanks for their efforts during the past year.

Success in this diphtheria immunization campaign will depend not only on the central leadership and plans, but on each individual member physician making an earnest effort to understand the plans, and loyally doing his individual share in carrying out the personal health service which is planned by his state and county public health committee.

RECOMMENDATIONS

The committee submits the following recommendations:

(1) The medical societies of the state and counties shall continue the assumption of leadership and responsibility for the general health of the citizens of New Jersey, and thereby preserve the personal and private relationship between physician and patient, which is the most desirable one for the health needs of the patient.

(2) The societies shall continue the diphtheria immunization campaign of babies and children as a major project.

(3) The public health committees shall continue to develop the plan of the public health hour in the physician's office by gradually incorporating in that hour other phases of public health and preventive medicine.

(4) The public health committees of the state and county societies shall act as clearing houses for all public health activities and also act as an advisory body to any group considering any type of health activity.

(5) Funds shall be provided in each state and county society for a central office organization to carry out this public health program.

STANLEY H. NICHOLS,

April 15, 1934

Chairman.

REPORT OF THE MEDICAL ADVISORY COMMITTEE TO THE STATE EMERGENCY RELIEF ADMINISTRATION

By SPENCER T. SNEDECOR, M.D.

To the House of Delegates:

A year ago the society launched upon this new endeavor of providing medical care to the indigent clients of the Emergency Relief Administration on a partial fee basis. It was a radical departure from the existing haphazard service previously available, undoubtedly forced by the huge emergency load of the indigent.

In a general way, much has been accom-

plished by this committee. The year's work has resolved itself into a series of problems.

Problem 1. The first task of the committee was to work out the details of the state-wide plan, the principles of which were approved by all but one county society and published in the Journal. About July 31, these were passed upon by the Emergency Relief Administration and our committee. We anticipated then that

there would be little else for the committee to do but to forward the detailed plan to all the county societies and county relief directors. Time has shown that this was taken as an empty announcement in many counties.

The set-up of the Emergency Relief work coöperation may best be explained by a diagram.

age and night calls. It must be strongly emphasized that the available relief funds for all services are strictly limited and a shortage in the near future is a distinct possibility.

In the majority of the counties the rates are \$1 for office and \$2 for house calls. In a few the rate is slightly lower.

Problem 4. An attitude of passive resistance

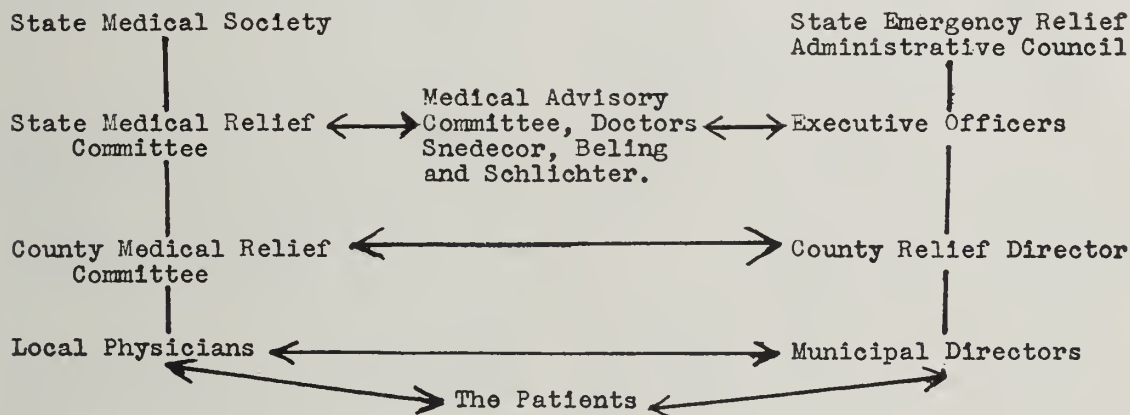


Diagram of the Organization and Relations of the Medical Advisory Committee

The three members acting as an executive committee of the medical group were appointed as a Medical Advisory Committee to the State Emergency Relief Administration by Mr. John Colt, who was then Director of Relief.

Problem 2. In order to organize the work at the beginning, the Councilors called district meetings of the County Medical Committees of all the counties in each district. Dr. Tooker, Dr. Wilkes, the chairman, and sometimes too Dr. Quigley and Dr. Beling attended these and explained the plan.

Slowly the system began to function. Encouraging reports began to come in from some of the counties. As a general trend, it seemed that the counties where the medical men organized the most actively and attained the best co-operation from the county director's office made the greatest strides.

Problem 3. Considerable difficulty occurred in establishing fee schedules and standard agreements. In fact, uniform agreements and satisfactory fee schedules have only just been signed in all the counties.

What is a fair fee schedule? The committee feels that the statement in the agreement "from one-half to two-thirds the customary fees" represents a fair basis. If we definitely point out that this is intended to recompense the physicians only partially for the services rendered, and further that there are not enough funds available to repay the doctors fully, then we can be fairly satisfied and overlook mile-

towards the plan continued in the relief agencies of Newark, Elizabeth and Trenton. In spite of the efforts made by the County Medical Committees, no headway could be made with the local directors. The State Committee forced the issue in each instance, and after numerous meetings reached working agreements in Newark, Elizabeth and ostensibly in Trenton.

Problem 5. In the large cities it became necessary to decide what share of the burden of the poor should be provided for under the Emergency Relief Administration plan, what share by clinics, and what share by city physicians.

The following principle was agreed upon as a working basis. A normal load should be carried by city physicians and clinics. The statistics for the year 1929 were selected as a normal load. All cases above this average number should be referred to private physicians.

In a general way, this is intended to work out that the chronically indigent may be cared for by city physicians, but the temporary indigent, those who formerly went to private physicians, should continue to do so.

Problem 6. An interpretation of the Relief Law was rendered by the Counsel of the Emergency Relief Administration late in December, which stated in brief that municipal employees, such as school physicians, could not receive Emergency Relief monies. This imme-

diately disturbed the smooth functioning of the plan. Particularly has this rule worked a hardship on the patients and physicians of rural communities where from one-half to two-thirds of the physicians became ineligible.

The law was studied from all angles but no remedy could be found except a legislative amendment. Meanwhile, the Middlesex Society was forehanded and had an amendment introduced into the Assembly which was passed and signed by the Governor. Then it was discovered that the wrong law was amended and a new act had to be drawn up and introduced. On April 9 Senate Bill No. 251 was passed and signed. All unfair restrictions as to what physicians may be authorized to care for their patients have now been removed.

Problem 7. In our original plan it was specified that authorizations should be given for a maximum of ten visits. For several reasons the committee modified this to make an original authorization of three visits; and subsequent authorization without reinvestigation up to ten.

Problem 8. No check on the bills submitted by physicians could be made unless a diagnosis was given. A number of objections were made to writing the diagnosis on the bill. A compromise plan, suggested by Dr. Tooker, was adopted. A list of cases treated and the diagnosis of each is sent to the County Medical Committee the first of each month. At the moment, this arrangement seems satisfactory.

Problem 9. When the Civil Works program began to function in November, injuries to the workers were compensated for under the terms of Federal Compensation. Immediately it was necessary for the Medical Society to recognize the need for control of this work to prevent the development of a "compensation racket". An agreement was signed with the State Civil Work Administration to the effect that the same set-up which was functioning on the Emergency Relief cases should also organize and control the Civil Works compensation cases. A very coöperative understanding was established with Mr. Allard, who has charge of these injuries. The fee schedule was on a basis of the customary fees for such work. A fair distribution of the cases to the physician of the patient's choice was obtained wherever practicable. Control of the medical charges and distribution of the work were secured by providing that the county claim agents must have the County Medical Committee certify all bills.

PRESENT PHASE

Meetings are being arranged in each county in the state where all the Municipal Directors, County Directors, Dr. Tooker of the State Emergency Relief Administration and Medical Advisory Committees will be present to take up the details of administration. In this way, it is felt that the directors and county committees will secure a better understanding of their responsibilities.

REPORTS FROM COUNTIES

It is difficult to give a comprehensive report of the results in each county. The rural counties are requesting mileage allowances. Work in these counties has been quite deranged during the past three months because of the exclusion of school physicians. We think it is fair to say that nearly all of them will be straightened out now.

Essex which has only just begun to function fully, reports "that the plan of operation has been proved to be good and that the administration is satisfied with the way it is working".

Monmouth points out a fact that is strikingly true almost everywhere—"a survey has not revealed one case of the use of medical aid as a single service to those not receiving full Emergency Relief maintenance". A number of minor points there require adjustment.

It is doubtful if the City of Trenton has yet been satisfactorily organized.

From a large survey throughout the state we believe that a fair degree of function is being attained.

HUDSON COUNTY

Last May the members of the Hudson County Society stated that while they would not oppose the plan for other counties, they did not wish it installed there; and, therefore, no attempt has been made to do so. In February, 1934, they reaffirmed their stand for the reasons quoted from their Bulletin: "To accept it would have meant a revolutionary change in our relationship to the public, a repudiation of our time-honored principles, the first step toward fee fixing for the entire profession, the stimulation of pauperization among our middle classes, and an enormous increase in taxes for our communities, reverting in part upon ourselves.

"After all, such a project has become obsolete if not already a defunct institution, and the Hudson County Medical Society deserves praise for its courageous and foresighted standing, which had been originally advocated and defended by us."

FINANCIAL RETURN

In the six months, September through February, a total of \$168,991 was paid to physicians: for hospitalization, \$305,248; and for medical supplies, \$82,141.

NATIONAL EXAMPLE

That our plan in New Jersey has been one of decided merit may be a fair conclusion. We have reason to believe that the Federal Relief Medical Regulations were largely suggested by the New Jersey plan. Inquiries have reached us from nearly every state in the Union about the principles and details of our New Jersey set-up.

In spite of our own inadequacies, we believe that New Jersey has foremost rank of any state in the adoption, organization and function of the Medical Relief work. This opinion is born out by a survey of the reports published in the state journals. Lack of medical organization and lack of coöperation by the relief agencies is generally noted. In a few counties in New York it is working well. Pennsylvania reports a serious lack of coöperation. In many of the states reports are very vague, some indicating opposition or dispute. Most of them reveal that little constructive organization has been done.

GENERAL SURVEY

Before making recommendations to the Society on this work, it is important that an analysis be made of our existing agreement, the status of the work, and the attitude of the physicians.

This whole plan has been an experiment in which the physicians receive payment directly from the state for medical services rendered to the poor. A mutual agreement was entered into by the Emergency Relief Administration and the State Medical Society. The status of the Medical Society and the amount of control it exerts in this plan can be broken into three phases:

(1) Authorization for medical service. Controlled by the Emergency Relief (public officials).

(2) Medical service. Controlled by the physicians.

(3) Payment. Controlled by the Emergency Relief (public officials).

Briefly it may be stated that the physicians furnish the service as *authorized and paid for by the Emergency Relief*. In a general way, the Emergency Relief must be considered as the public representative, because it is held closely accountable to the people for the money expended in providing care for the poor.

CONSTRUCTIVE RESULTS

(1) Fairly good medical care to the clients of the Emergency Relief Administration.

(2) A monetary return to the doctors not sufficient, but justifying the effort spent.

(3) Development and integration of competent state and county medical organization capable of exerting a fair control of the situation.

On the reverse side should be mentioned, 1, the inadequacies and inequalities of the plan; 2, the unfair attitudes of local directors, which is gradually but definitely being corrected; 3, the difficulties of organizing and preventing discriminations have disgusted a number of physicians; 4a, the beurocratic technicalities of correct procedures have shown us the undesirability of extending state medicine further than is necessary to provide medical care for the poor with fair remuneration to the physician.

In deciding whether or not to continue our coöperation, a vital consideration seems to us to be—Is there some better way if we give this up?

Medical care for their clients must be provided by the Emergency Relief Administration. If it cannot be carried on through the present agreement, then one or both of the other methods must be used. Free clinics will be taken advantage of; or where that burden is too great, contract or salary practice such as paying physicians by the hour to hold clinics or visit the homes, will be instituted.

With due consideration for the results obtained and with the promise of better and more equitable functioning of the plan as we go on, your committee recommends that the Medical Society of New Jersey enter into an extension of its agreement with the Emergency Relief Administration for a period of one year or more, or until it shall declare the emergency has ceased.

This report was approved at a meeting of the committee on April 12, 1934.)

SPENCER T. SNEDECOR,

Chairman

CHRISTOPHER C. BELING

CHARLES H. SCHLICHTER

FREDERIC J. QUIGLEY

J. BENNETT MORRISON

WELLS P. EAGLETON

JAMES S. GREENE

FRANK G. SCAMMELL

ALDRICH C. CROWE

JAMES A. FISHER,

Secretary.

SPECIAL COMMITTEE ON MATERNAL WELFARE

A. W. BINGHAM, M.D.

To the House of Delegates:

The *Maternal Welfare Committee* reports some progress during the year. There were two meetings held with the members of the various county commissions.

The meeting at Atlantic City in June 1933, was preceded by an excellent address by Dr. Phillip Williams of Philadelphia, but did not have the attendance it should have received. Reports were given from Bergen, Burlington, Camden, Mercer, Monmouth, Salem, Somerset, and Sussex Counties. It was voted that an effort be made to interest the counties not yet doing much in maternal welfare.

The second meeting was held in Newark on January 18, 1934. Thirteen counties were represented by thirty members,—Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Hudson, Mercer, Monmouth, Ocean, Passaic, Somerset, and Union. There were also a number of guests including some of the health officers as well as Dr. Edward A. Schumann of Philadelphia. Dr. Walter Mount read a resolution which the Essex County Maternal Welfare Commission has offered to the council of the county society recommending consultation in prolonged labors and abnormal obstetrical cases. (This resolution has since been adopted by the Essex County Medical Society.) The discussion was followed by a dinner given by the Maternal Welfare Commission of Essex County, after which the meeting adjourned to the Academy of Medicine and Dr. Schumann gave a talk on "Leaves from an Obstetrician's Note Book". This paper was interesting and instructive and was freely discussed.

On March 7, 1934, the New York Academy April 15, 1934.

of Medicine held a joint meeting with the Medical Society of the County of New York and the New York Obstetrical Society to discuss the Maternal Mortality Report. The chairman of the New Jersey State Committee was asked to take part in the discussion and tell about the work done here. A number of favorable comments have been received since this meeting, the consensus of opinion being that New Jersey is proceeding along the right lines.

The committee hopes soon to have the co-operation of all the counties. Three of the committee have been asked to speak in May at the Burlington County meeting. We are very glad to have this opportunity to discuss maternal welfare problems.

The next meeting of the committee with the Maternal Welfare Commissions of the various counties will be held at Atlantic City on June 6th, at 5 P. M., when Dr. Robert L. DeNormandie of Boston will be the speaker and there will be reports from the different counties. A full representation is urged.

The committee recommends for this year greater coöperation among the physicians doing obstetrics and more consultations in complicated or prolonged labors regardless of fee. New Jersey is one of the leaders in maternal welfare work. Let us keep our place.

R. A. MacKENZIE,
P. DuBois BUNTING,
JOHN F. CONDON,
CARL ILL,
WALTER B. MOUNT,
NORMAN J. QUINN,
A. W. BINGHAM, *Chairman*

REPORT OF THE COMMITTEE ON HONORARY MEMBERSHIP

By T. W. HARVEY, M.D.

To the House of Delegates:

As chairman of the Committee on Honorary Membership I wish to report that there have been no applications made for honorary

membership, or any names suggested for such membership.

T. W. HARVEY, *Chairman*

May 1, 1934

SPECIAL COMMITTEE ON CONSTITUTION AND BY-LAWS

CHARLES J. MURN, M.D.

To the House of Delegates:

The Committee on Constitution and By-Laws has held no meeting this year.

President Quigley has suggested an amendment to Section 2, Chapter VIII of the By-Laws (page 28), which now reads as follows: "Section 2. The Standing Committees shall be:

Nominating Committee
Committee on Finance
Scientific Work
Program and Arrangements

Publication

Honorary Members

Welfare

Hospitals and Medical Education."

Dr. Quigley proposes to add the words: "and such additional Committees as the House of Delegates may determine."

Since the last copy of the Constitution and By-Laws was printed in 1929, the chairman recommends that a new edition, brought up to date, shall be prepared.

May 1, 1934

CHARLES J. MURN

THE STATE BOARD OF MEDICAL EXAMINERS OF NEW JERSEY

By JAMES J. MCGUIRE, M.D., F.A.C.P.,

Secretary

To the House of Delegates:

The following is a brief report on the activities of the State Board of Medical Examiners of New Jersey from June 1, 1933 to April 1, 1934:

Licenses Issued

Physicians and Surgeons by Examination	153
Physicians and Surgeons by Endorsement	138
	— 291
Osteopaths by Examination	35
Osteopaths by Endorsement	2
	— 37
Chiropodists by Examination	94
Midwives by Examination	1
	— 1
Total	423

Total Number of Physicians and Surgeons Examined	163
Total Number of Physicians and Surgeons failed	9
Percentage of Failures	5.5

Total Number of Osteopaths Examined	38
Total Number of Osteopaths Failed	3
Percentage of Failures	7.8

Total Number of Chiropodists Examined	151
Total Number of Chiropodists failed	57
Percentage of Failures	37.7

Revocation of Licenses

The license of one physician was revoked for the practice of criminal abortion. The certificates of license of two midwives were revoked for conviction of the practice of criminal abortion.

Court Decisions

The College of Mecca of Chiropractic applied to the Board for a license to conduct a school teaching a method of treatment of disease, pursuant to Chapter 184, P. L. 1924. The Board sent the College a copy of the requirements to be met by Class A. medical schools in seeking a license under the Law, and advised the applicant that the Educational Committee would inspect the College at any time they might suggest. Instead of arranging a date for the inspection, the College made an application to the Supreme Court for writ of certiorari, in which it was urged that Chapter 184, P. L. 1924, be declared unconstitutional and the action of the Board in fixing such requirements be set aside.

The Supreme Court held:

"The statute was under like attack by the prosecutor in *State Board of Medical Examiners of New Jersey vs. College of Mecca of Chiropractic, Inc.*, prosecutor, 6 Misc. 677, aff. by the Court of Errors and Appeals, 106 N. J. L. 602, on the opinion below. This court held in that case that the requirements of the statute were just and reasonable regulations, that the legislature was within its rights in passing the act and that the act 'does not offend against any constitutional provision.' That holding is, we consider, dispositive of all points presented on the prosecutor's brief and, inasmuch as the opinion was adopted by the Court of Errors and Appeals, it stands as an adjudication which this court will not disturb.

"The writ of certiorari is dismissed, with costs."

Another important decision was in the case of a licensed chiropractor using an electronic machine, and using the title "Dr." without qualifying it by the word "Chiropractor". The Supreme Court affirmed the trial court. An appeal was taken by the defendant to the Court of Errors and Appeals and the decision of the Supreme Court was affirmed.

The following is a statistical summary of the legal work accomplished by the Board:

PROSECUTIONS	
<i>Court Cases</i>	
Convicted, pleaded guilty or settled.....	46
Lost (3 chiropody and 1 medical)	4
Listed in Court and not yet tried	16
No Service	1
	67

<i>Decisions of Higher Courts</i>	
Won by Board in trial court—judgment of trial court affirmed by the Supreme Court, appeal taken to Court of Errors and Appeals by defendant, Supreme Court affirmed	2

<i>Hearings for Revocations of License</i>	
Complaint dismissed with reprimand.....	1
License Revoked	3
Cases Pending	2
	6
	75

<i>Analysis of Inspections and Investigations</i>	
Total Number of Investigations and Inspections made	210
Total Number of visits and treatments received in making the investigations and inspections	1,239
Average Number of Visits per Investigation	5.9

<i>Type of Case Investigated</i>	
Druggists	40
Prescribing herbs and drugs	41
Unlicensed Chiropractors	5
Chiropractors exceeding license	7
Osteopaths exceeding license	8
Chiropodists exceeding license	2
Unlicensed chiropodists	2
Electro-therapy	6
Naturopaths	8
Midwives exceeding license	1
Laying-on-of-hands	1
Medical — Revocation	5
Midwifery — Revocation	3
Colonic Therapy	2
Physio-Therapy	6
Unlicensed medical physicians	12
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168TH ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY

HADDON HALL, ATLANTIC CITY

Tuesday, Wednesday and Thursday, June 5, 6 and 7, 1934

OFFICIAL EVENTS

1. Board of Trustees Meeting, Monday evening, 8.30 o'clock.
2. Nominating Committee Meeting, Tuesday evening, 8.30 o'clock.
3. House of Delegates.

First Session, Tuesday Afternoon, 2.00 o'Clock

ORDER OF BUSINESS

- a. Appointment of Reference Committees.
- b. Reception of Annual Reports of Officers and Committees.
Five minutes will be allowed to each officer or chairman to amplify or explain his reports. The reports are published in this Journal, pages 255-294, and reprints will be mailed to every Delegate and Alternate for his study and for his personal use during the meetings.
- c. New Business.
- d. Suggestions for a State Cancer Committee.

Second Session, Wednesday Afternoon, 2.00 o'Clock

ORDER OF BUSINESS

- a. Report of Nominating Committee.
- b. Elections. (No other business.)

Third Session, Thursday Afternoon, 2.00 o'Clock

ORDER OF BUSINESS

- a. Reports of Reference Committees.
 - b. Unfinished Business.
 - c. Address of the President-Elect, Launcelot Ely, M.D.
4. Conference of Medical Advisory Committee on the State Emergency Administration, with the Chairmen of the County Committees, Wednesday morning, 10.00 o'clock.
 5. Scientific Meetings.
 - a. General meetings.
 - b. Section meetings.(See programs on pages 296-298.)
 6. Woman's Auxiliary.
 - a. Executive Board Meeting, Tuesday afternoon, 2.30 o'clock.
 - b. General Session.
 - c. Luncheon Session.(See programs on page 299.)
 7. President's Banquet (dancing to follow) under the auspices of the Woman's Auxiliary, Wednesday evening, 7.30 o'clock.
 8. Exhibits.
 - a. Scientific.
 - b. Commercial.
 - c. Arts and Hobbies by members of the Society.

GENERAL MEETINGS

First Meeting, Tuesday Evening, June 5, 1934

MEDICAL ECONOMICS

8:30 to 9:00 o'clock

1. West Coast Experiments in Providing Medical Service

Seth A. Brumm, M.D., Philadelphia, Pa.,
President-Elect, Philadelphia County
Medical Society

9:00 to 9:30 o'clock

2. The Philosophy of Medical Service and Its Present-Day Applications

Frederick Elliott, M.D., Brooklyn, N. Y.,
Chairman Committee on Medical Eco-
nomics of the Medical Society of the
State of New York

9:30 to 10:00 o'clock

3. Medical Practice Problems in New Jersey
Thomas K. Lewis, M.D., Camden, Chair-
man Sub-Committee on Medical Prac-
tice of the Welfare Committee of the
Medical Society of New Jersey

10:00 to 10:30 o'clock

4. General Discussion; Leader, Edward W.
Sprague, M.D., Newark.

Second Meeting, Wednesday, 12 Noon June 6, 1934

Address of the President: Frederic J.
Quigley, M. D.

Third Meeting, Wednesday Afternoon, June 6, 1934

SCIENTIFIC PROGRAM

2:00 to 2:30 o'clock

1. Allergic Diseases
Robert A. Cooke, M.D., Special Consul-
tant, Allergic Clinic, Roosevelt Hospi-
tal, New York City
Discussors: George P. Meyer, M.D.,
Camden, Dean Marquis, M.D., Orange

3:00 to 3:30 o'clock

2. Arthritis considered as a Systemic Dis-
ease
Reginald Burbank, M.D., Chief of Arthri-
tic Clinic, French Hospital, New York
City

Illustrated with lantern slides

Discussors: John Gray, M.D., Newark;
B. Franklin Buzby, M.D., Camden

4:00 to 4:30 o'clock

3. Sub Total versus Total Hysterectomy
Max Danzis, M.D., Newark
Illustrated with lantern slides

Discussors: William J. Carrington, M.D.,
Atlantic City; E. Zeh Hawkes, M.D.,
Newark; Edgar A. Ill, M.D., Newark

5:00 to 5:30 o'clock

4. Prenatal Care in Relation to Maternal and
Infant Mortality

Robert L. DeNormandie, M.D., Boston,
Mass.

Discussors: Saumel A. Cosgrove, M.D.,
Jersey City; Norman J. Quinn, M.D.,
Atlantic City

Conference of County Maternal Welfare
Committees

Fourth Meeting, Thursday Evening, June 7, 1934

SYMPOSIUM ON PNEUMONIA

8:00 to 8:30 o'clock

1. Pneumonia
Llewellyn F. Barker, M.D., Baltimore,
Maryland

8:40 to 9:10 o'clock

2. Pathology of Pneumonia
Harrison Martland, M.D., Newark

9:15 to 9:35 o'clock

3. Pneumonia in Children
Walter Stewart, M.D., Atlantic City
Discussors: Arthur Stern, M.D., Eliza-
beth; Arthur M. Dannenberg, M.D.,
Philadelphia, Pa.

9:50 to 10:10 o'clock

4. X-Ray Diagnosis
Joseph E. Roberts, M.D., Camden
Discussors: George S. Reitter, M.D., East
Orange; J. B. Edwards, M.D., Engle-
wood

10:30 to 10:50 o'clock

5. Surgical Aspects
Richard H. Dieffenbach, M.D., Newark
Illustrated with lantern slides

SECTION MEETINGS

SECTION ON THE EYE, EAR, NOSE AND THROAT

**First Meeting, Wednesday Morning
June 6, 1934**

9:00 to 9:30 o'clock

1. Diseases of the External Ear
Charles N. Dezer, M.D., Hackensack
Discussor: E. M. Tennis, M.D., Englewood

9:30 to 10:00 o'clock

2. The Surgical Anatomy of Neck Infections of Dental Origin
Joseph A. Miller, M.D., South Orange
Discussor: Henry C. Barkhorn, M.D., Newark

10:00 to 10:30 o'clock

3. Pathways of Intracranial Infection from the Ear, Nose, and Throat, with Diagnosis and Treatment
Henry C. Barkhorn, M.D., Newark
Discussor: Earl LeRoy Wood, Newark

10:30 to 11:00 o'clock

4. Meningitis from Petrous Apex Infection
Weils P. Eagleton, M.D., Newark
Discussor: W. R. Tymeson, M.D., Orange

11:00 to 11:45 o'clock

5. Sinusitis in Children
Lyman Richards, M.D., Surgeon in Otolaryngology to the Children's Hospital, Boston, Mass.
Discussor: James A. Fisher, M.D., Asbury Park

**Second Meeting, Thursday Morning
June 7, 1934**

9:00 to 9:20 o'clock

1. Diagnostic Value of Optic Neuritis and Choked Disc in Nervous and Mental Diseases
Archangelo Liva, M.D., Hackensack
Discussor: C. C. Beling, M.D., Newark

9:30 to 9:50 o'clock

2. Some Practical Observations Concerning Ophthalmic Lenses
A. Russell Sherman, M.D., Newark
Discussor: J. S. Shipman, Camden

10:00 to 10:30 o'clock

3. Uveitis
R. W. Baeseman, M.D., Asbury Park
Discussor: W. G. Mengel, M.D., Camden

10:30 to 11:00 o'clock

4. Report of the Dr. Kipp Memorial Committee

11:00 to 11:45 o'clock

5. Keratoplasty
Ramon Castroviejo, M.D., Institute of Ophthalmology, Columbia-Presbyterian Medical Center, New York City
Discussor: E. S. Sherman, M.D., Newark

SECTION ON PEDIATRICS

Wednesday Morning, June 6, 1934

10:00 to 10:30 o'clock

1. The Treatment of Erysipelas in Children
Kenneth Blanchard, M.D., East Orange, and H. O. Bell, M.D., Belleville

Symposium on Diseases of Blood

10:45 to 11:15 o'clock

2. Hemorrhagic Blood Dyscrasias—Diagnosis and Treatment
Hyman I. Goldstein, M.D., Camden

11:15 to 11:35 o'clock

3. The Clinical Control of Chronic Hemorrhagic States in Infancy and Childhood

- I. Newton Kugelmass, M.D., New York City

11:35 to 12:15 o'clock

4. The Clinical Applications of the Measurement of the Diameter, the Volume, and the Hemoglobin Content of the Red Blood Cell in Anemia
Russell S. Haden, M.D., Cleveland, Ohio

12:15 to 12:35 o'clock

5. Erythroblastosis in the New Born
Robert R. White, M.D., East Orange
Discussion of papers by: N. Rosenthal, M.D., New York City; Robert A. Kil-duffe, M.D., Atlantic City

SECTIONS ON PEDIATRICS AND ON SCHOOL PHYSICIANS

Joint Meeting, Thursday Morning, June 7, 1934

10:00 to 10:30 o'clock

1. The Prevention in Adolescent Children of Acne Vulgaris
Stanley Nichols, M.D., Asbury Park
Discussor: Irving Okin, M.D., Passaic

10:30 to 11:00 o'clock

2. Adult Pulmonary Tuberculosis in Children with Treatment by Compression Therapy
Samuel B. English, M.D., Glen Gardner, and Max Gross, M.D., Glen Gardner
Discussors: John Runnells, M.D., Scotch Plains; Stanley Nichols, M.D., Asbury Park

11:00 to 12:00 o'clock

3. Contagiousness of Acute Respiratory Infections in Children from the Rhinologist's Standpoint
William John Greenfield, M.D., Hackensack
Discussors: Kenneth Blanchard, M.D., East Orange; Lewis W. Brown, M.D., Newark

12:00 to 12:30 o'clock

4. Evaluation of the Various Procedures of Diphtheria Immunization
H. Louis Fuerstman, M.D., Newark

12:30 to 1:00 o'clock

5. A Discussion of Current Problems in School Health Work
Allen G. Ireland, M.D., Trenton

SECTION ON RADIOLOGY

First Meeting, Thursday Morning, June 6, 1934

10:00 to 10:30 o'clock

1. The Problem of Silicosis—A Practical View-point
R. Pomeranz, M.D., Newark

10:30 to 11:00 o'clock

2. Osteogenic Tumors
John Tidaback, M.D., Summit, and A. F. Galasso, M.D., Morristown

11:00 to 11:30 o'clock

3. Report of a Case of Foreign Body in the Esophagus
Erwin Reissman, M.D., Newark

11:30 to 12:00 o'clock

4. Roentgen Diagnosis of Lesions of Esophagus
Charles F. Baker, M.D., Newark, and W. J. Marquis, M.D., Newark

12 to 1 o'clock

5. Why Gastric Cancers Show Characteristic Roentgen Findings
Lewis Gregory Cole, M.D., Roentgenologist, Fifth Avenue Hospital, New York City

Second Meeting, Thursday Morning, June 7, 1934

10:00 to 10:30 o'clock

1. Protracted External Radiation in the Treatment of Neoplasms of the Upper Respiratory Tract
Milton Friedman, M.D., Newark

10:30 to 11:00 o'clock

2. Suppurative Hip in Children
G. Herbert Taylor, M.D., Maplewood

11:00 to 11:30 o'clock

3. Intrathoracic Anatomy from the Roentgenologist's Standpoint
William Wallace Maver, M.D., Jersey City

11:30 to 12:00 o'clock

4. Report of a Case of Mediterranean or Sick Cell Anemia
Austin Vogel, M.D., Elizabeth

12 to 1 o'clock

5. The Recognition of Some Forms of Intracranial Pathology
Charles W. Schwartz, M.D., Director of the X-Ray Department of the Neurological Institute of the Columbus-Presbyterian Medical Center, New York City

WOMAN'S AUXILIARY

Program of the Seventh Annual Meeting

Tuesday, June 5th, 2:30 P. M.

EXECUTIVE BOARD MEETING

Garden Room

Wednesday, June 6th, 9:30 A. M.

GENERAL SESSION

Garden Room

PAGES

Mrs. Stuart Benedict, Hudson
Miss Dorothy Underwood, Gloucester
Miss Harriet Hubbard, Union
Mrs. Louis Perkel, Hudson
Miss Jean Ballinger, Essex
Miss Mary Lea Davis

ORDER OF BUSINESS

Call to Order—Mrs. Harry V. Hubbard, President
Roll Call
Tribute to Departed Members
Minutes of Last Meeting—Mrs. W. H. Gilliam, Recording Secretary
Report of the Treasurer—Mrs. Edward W. Clarke, Treasurer
Report of the Corresponding Secretary—Mrs. Willig Gray
Report of Standing Committees
Report of Delegates to the Woman's Auxiliary to the A. M. A.
Report of the County Auxiliary Presidents
Report of the President—Mrs. Harry V. Hubbard
Report of the Nominating Committee

Unfinished Business

Election of Officers

Installation of Officers

Program for the Year 1934-1935—Mrs. A. J.

Casselman, President

Appointment of Committee Chairmen

Wednesday, June 6th, 1:00 P. M.

AUXILIARY LUNCHEON

Rutland Room

Physicians and members of their families are invited

Ticket \$1.50 each, with a rebate allowed to guests of the hotel (American plan)

GUEST SPEAKERS

Mrs. Robert W. Tomlinson, President-Elect of the Woman's Auxiliary to the American Medical Association
Lancelot Ely, M.D., incoming President of the Medical Society of New Jersey

Wednesday, June 6th, 7:30 P. M.

President's Banquet (dancing to follow)

Rutland Room

Physicians and members of their families are invited

Tickets \$3.00 each, with a rebate allowed to guests of the hotel (American plan)

Thursday, June 7th, 9:30 A. M.

NEW EXECUTIVE BOARD MEETING

Garden Room

HOSTESSES AT LUNCHEON AND DINNER

DANCE

Past Presidents

Mrs. A. Haines Lippincott
Mrs. James Hunter
Mrs. H. Roy Van Ness
Mrs. George L. Orton
Mrs. John Nevin
Mrs. Charles Franklin Adams

County Auxiliary Presidents

Mrs. Joseph Poland, Atlantic County
Mrs. Alexander, Bergen County
Mrs. G. E. McDonnell, Burlington County
Mrs. A. Haines Lippincott, Camden County
Mrs. Allan Carson, Cape May County
Mrs. F. J. McCauley, Essex County
Mrs. E. E. Downs, Gloucester County
Mrs. Frenk Nicholson, Hudson County
Mrs. William C. Irvins, Mercer County
Mrs. Walter Gosling, Monmouth County
Mrs. A. Woodhouse, Ocean County
Mrs. William Dwyer, Passaic County
Mrs. Lancelot Ely, Somerset County
Mrs. H. H. Bowles, Union County

ATLANTIC CITY GENERAL COMMITTEE

Mrs. David Allan	Miss K. DeS. Corcoran
Mrs. Joseph Poland	Mrs. Hilton Read
Mrs. Richard Bew	Mrs. V. E. Johnson
Mrs. James Mason	Mrs. Percy Clarke Joy
Mrs. Robert Bradley	Mrs. James North
Mrs. Robert A. Bradley	Mrs. Charles Sinkerson
Mrs. Samuel Gorson	Mrs. Edward Guion
Mrs. Lawrence Wilson	Mrs. Myrtle Frank
Mrs. Emanuel Mally	Mrs. Charles Hyman
Mrs. Bernard Crane	Mrs. Baxter Timberlake
Mrs. Stanley McGeehan	Mrs. Richard Bew, Sr.
Mrs. Carl Surran	Mrs. George Poland
Mrs. Louis Rosenberg	Mrs. Harry Stubin
Mrs. E. H. Harvey	Mrs. Blair Stewart
Mrs. Milton Ireland	Mrs. W. D. Olmstead
Mrs. Raymond Williams	Mrs. Daniel Reyner
Mrs. Robert A. Kilduff	Mrs. William Carrington
Miss Nellie McGurran	Mrs. L. M. Walker
Miss Elsie Mae Caperson, R. N.	

County Society Reports

ATLANTIC COUNTY

Robert A. Kilduffe, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held in the Music Room of the Chalfonte Hotel on Friday, April 13, 1934, the President, Dr. D. B. Allman, presiding, and forty-five members present.

The application of Eugene R. Westcott, D.D.S., for associate membership was referred to the Board of Censors.

The Secretary read a letter from the Hudson County Society embodying a resolution passed by that society stating that the society considered the State Society dues are too high, and that State dues of \$7 be recommended. After some discussion, it was decided to acknowledge receipt of the letter with no comments.

Dr. E. H. Harvey, reporting for the Public Health Committee, stated that the survey of pre-school children for diphtheria immunization was nearly completed, and that those members who had expressed willingness to do this work would shortly receive further information regarding it.

Dr. J. S. Irvin, reporting for the Medical Advisory Committee, stated that the work being referred from the dispensary of the Atlantic City Hospital to the doctors' offices through the E. R. A. had almost tripled the amount of medical care given through the E. R. A.

Dr. Irvin also stated that a law had just been passed giving the Judicial Council of the E. R. A. the right to make regulations under which physicians holding state, county and municipal appointments may do E. R. A. work. As soon as these regulations are formulated, these doctors will be able to take care of E. R. A. patients.

Dr. W. E. Darnall reported for the Library Committee that several new additions had been added to the Medical Branch Library.

Dr. W. J. Carrington reported that the post-graduate lectures had been completed, twenty-five members having been enrolled. He stated that he believed the course had been very successful.

Dr. W. P. Conaway reported for the Broadcasting Committee by letter, stating that there would be two more addresses by Drs. Gorson and Kilduffe on April 20 and 27 respectively, and that these would conclude the broadcasting program for this year. Dr. Allman thanked Drs. Conaway and Carrington for their work on the Post-Graduate Education and Broadcasting Committees.

Dr. Harry Subin, Chairman of the Entertainment Committee, reported that an outing would be held on June 22 at Dox Folly through the courtesy of Drs. Mason, Davidson, and Uzzell. The outing will be attended by members of the medical, dental, and pharmaceutical societies, and the legislators of this county. There will be athletics and swimming, and a dinner at 6.30 for \$1.50 per person at which time there will be addresses. It is hoped to bring about a closer relationship among the societies represented, and also between them and the county legislators. Legislation affecting the interests of

these professions is frequently before the Legislature, and it is the legislators of the county to whom we must look for aid in passing or opposing such legislation.

The scientific program was presented by Dr. Alfred E. Stengel, Professor of Medicine, University of Pennsylvania, on "Problems in Medical Diagnosis". The paper was of great interest to the members of the society and was discussed in general terms by Drs. Scanlon, Barbash, Read, Marvel, Salasin and others.

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular meeting of the Bergen County Medical Society was held April 10 at the Englewood Hospital, Dr. A. Liva, President, presiding.

Dr. Walter L. Liefeld, of Rutherford, was elected to regular membership on transfer from New Castle County, Delaware.

Communications were as follows:

From Dr. H. J. Perlberg, Secretary of the Hudson County Medical Society, expressing the view of that society that the State dues were too high and recommending a maximum of \$7.

Legislative Bulletin No. 5.

Replies from our Assemblymen in regard to Assembly Bills 303, 332 and 313. Dr. Liva stated that Assemblyman Schroeder promised our Welfare Committee that he would cooperate with the Medical Society to try to keep Assembly Bills 303 and 332 in committee.

Dr. S. T. Snedecor mentioned that S-252 (the E. R. A. Amendment), removing restrictions as to which doctors can do E. R. A. work, had become law.

Dr. S. T. Snedecor announced a Counselor District meeting on Medical Economics to be held at the Newark Academy of Medicine on April 12.

The Secretary then read the resolutions that the Executive Committee had passed in regard to the State Society dues:

"Whereas, The Hudson County Society has passed and circulated a resolution requesting that the dues of the State Medical Society be reduced to \$7 per year; and

"Whereas, The Bergen County Medical Society believes this to be a matter of vital importance to all component societies; and

"Whereas, The Bergen County Medical Society does not condone extravagance and has sought to decrease the expenses and salaries of the State Society during the past few years on the basis of performance accomplished; and

"Whereas, The Bergen County Medical Society believes that a stronger and even more active State Medical Society organization is necessary in these difficult times to promote the welfare of the profession.

"Be it resolved that, since more direct benefit to the members has accrued through the activities of the State Society this year than ever before, the

Bergen County Medical Society does not feel that a reduction of dues should be made at this time, and

"Be it further resolved that, a copy of this resolution shall be sent to every county society."

Dr. Kilts asked what were the salaries of the paid officers of the State Medical Society. After explanation by Dr. A. Liva, Dr. S. Alexander moved that the Bergen County Medical Society go on record in favor of the resolutions and that a copy of the resolutions be sent to the Secretary of each component society of the State Medical Society. This was seconded by Dr. Corn and passed unanimously.

The Secretary, as Chairman of the Public Health Committee, announced that the diphtheria immunization program had met some opposition from the Parent-Teacher Association and boards of education. Dr. S. Alexander stated that, presiding at an open meeting of the Public Health and Sanitary Association, P.-T. A. and boards of education, he had explained that our diphtheria immunization program should not interfere with the school children but should concentrate on the pre-school child.

The meeting was then turned over to Dr. Charles Littwin who was in charge of the scientific session, at which the members of the Woman's Auxiliary were present as guests of the society. He introduced Miss Gertrude Eckhardt, Executive Secretary of the Bergen County Tuberculosis and Health Association, who talked about the types of cases that are referred to the Tuberculosis Association and how they are handled.

Dr. Bernard Sachs, President New York Academy of Medicine, Consulting Neurologist, Neurological Institute, New York Medical Center, was the speaker of the evening. The subject was "This Oversexed World". He emphasized particularly the fact that the mother should give the necessary sex information to her daughter at the proper time, and that the father should give the necessary sex information to the boy at the proper time. He felt that the mother should never attempt to give such information to her son.

After discussion by Drs. Corn, Goldberg, Wilson, and Sachs, the meeting adjourned for refreshments.

BERGEN COUNTY PUBLIC HEALTH ASSOCIATION

The Bergen County adaptation of the State Medical Society's plan for the immunization of children against diphtheria was presented to the representatives of the seventy-one boards of health of Bergen County at their regular quarterly meeting on Monday evening, April 9, 1934. A group of speakers consisting of Mr. William H. Macdonald, Chief of the Bureau of Local Health Administration of the State Department of Health, Dr. Leroy A. Wilkes, Executive Secretary of the State Medical Society, and Dr. George M. Knowles, Chairman of the Public Health Committee and Secretary of the Bergen County Medical Society, presented the plan. The Bergen County Public Health and Sanitary Association had invited representatives of the boards of education and the parent-teacher asso-

ciations of the county to be present at this meeting. There were about 350 persons present. Owing to unfortunate publicity with reference to the proposed plan, a somewhat mistaken idea as to the objectives of the program was held by certain members of the group, particularly members of the parent-teacher associations. Their objections were very ably and satisfactorily met by Dr. Wilkes in his discussion of the objectives of the State-Wide Plan.

Mr. Macdonald reviewed the progress made in the State of New Jersey in combating diphtheria. He pointed out that for obvious reasons the program of immunization was originally directed to the school-age group. He showed how the discovery and utilization of antitoxin, and later of toxin-antitoxin, had influenced the case and death rates from diphtheria for a period of thirty years. He pointed out the marked reduction in the number of cases of diphtheria throughout the state, and showed how the methods employed up to this time had succeeded in materially cutting the case and death rates of this disease. He, however, drew the attention of the group to the glaring defeat in the present scheme in most communities in that the major effort in protecting children against diphtheria is directed at the school-child. He suggested that, in view of the fact that sixty per cent of all cases of diphtheria occur in children under school age, emphasis should very properly be placed on the lower age groups.

Dr. Wilkes, following Mr. Macdonald, made it plain to the group that it was not the purpose of the State Medical Society to have the very effective work now being carried on discontinued, but rather that the work be expanded in such a manner as to immunize the child early in life and thus avoid the hazard of exposing him to diphtheria during that period of his life when he is most susceptible.

Dr. Wilkes stated that the physical work of immunizing the child had always been performed by physicians. It was the opinion of the members of the State Medical Society, and indeed their reason for advancing this scheme, that a more complete job of immunizing the children would be done if the work were placed where it rightfully belongs, in the hands of the family physician in private practice. Dr. Wilkes pointed out that the State Medical Society was thoroughly cognizant of the work done throughout the state by the various lay groups who had interested themselves in diphtheria immunization, and expressed the opinion that the program as carried out up to this time was a logical and proper one. Dr. Wilkes emphasized the fact that the need for lay coöperation in this newer plan was every bit as great as in the program carried out until this time; and that the very definite task of educating the general public as to the value of diphtheria protection still had to be carried on. He expressed the opinion that after a period of time the proposed scheme would result in the immunization of a higher percentage of our population than does the present one. He pointed out that this protection would be given at an age when it would be most beneficial.

Dr. Wilkes particularly stressed the importance

of the public health nurse in this entire program, pointing out that she could ably assist the physician in persuading the parent to have this work done.

In conclusion, Dr. Wilkes asserted that in effect this proposed scheme would not result in the abandonment of the present facilities for the immunization of children against diphtheria, but would actually create upward of 3000 additional places where this work would be done. It would add to our forces 3000 competent men, family physicians, who are on terms of greatest intimacy with the individuals of the state and who enjoy the confidence of the general public as does no other group of persons.

Dr. George M. Knowles, who followed Dr. Wilkes, described how the program was to be put into effect in Bergen County. He pointed out that the co-operating physicians were not confined solely to members of the Bergen County Medical Society, but that all physicians practicing in Bergen County had been invited to coöperate. He stressed the need on the part of both the local health departments and the medical society for information as to the number of children who had already been immunized. He asserted that in order for the scheme to be successful, all coöperating physicians must report children immunized to the local health departments.

Dr. Knowles declared that the Bergen County Medical Society was prepared to assume all responsibility for criticisms that may be directed toward any health department for its participation in the program.

He asked all local boards of health who planned to coöperate with the medical society to notify the society as soon as possible.

Following Dr. Knowles' remarks a number of questions were asked from the floor. The questions took the line of expressing fear that the present work done, particularly by the parent-teacher associations in rounding up children, may be adversely affected by the program. Dr. Wilkes, very definitely, allayed any such fear and reassured the organization that this program was not to be revolutionary but was to effect a gradual change.

Dr. Knowles, in answering questions, stressed the importance of close coöperation between the lay groups and the medical profession.

The impression left with the great majority of persons present was that the program proposed by the physicians warranted careful consideration and participation on the part of boards of health, parent-teacher associations, school boards and all other organizations interested in public health work.

L. VAN D. CHANDLER,
Health Officer, and Secretary of the
Bergen County Public Health
Association.

CAMDEN COUNTY

March Meeting

Vincent Del Duca, M.D., Reporter

The regular meeting of the *Camden County Medical Society* was held in the Camden City Dispensary Building, March 6, 1934, at 9 p. m., Dr. T. B. Lee,

President, presiding, and 78 members and guests present.

The guest speaker, Dr. I. Ravdin, Associate Professor of Surgery, University of Pennsylvania Medical School, read a paper on "End Results of Biliary Tract Disease". A comprehensive survey of over 100 cases of gall-bladder disease which had been operated on and followed up over a two-year period was presented.

Discussion was opened by Dr. Paul M. Mecray, who was followed by Drs. W. J. Barrett, I. E. Deibert, Reuben Sharp, H. I. Goldstein, W. H. Jack, William Shafer, A. J. Casselman, A. S. Ross and I. Ravdin.

Drs. P. H. Thompson, 4612 Westfield Avenue, Camden, N. J.; Marcus F. Wheatland, Jr., 727 Walnut Street, Camden, N. J.; and H. E. Primas, 772 Pine Street, Camden, N. J., were elected to membership, and Dr. Frank P. Stone, Tomlinson Avenue, Laurel Springs, N. J., was proposed.

Dr. A. H. Lippincott having automatically become a permanent member of the House of Delegates of the State Society by being a Past-President, Dr. T. B. Lee was elected a delegate. Dr. W. J. Barrett was elected a delegate to fill the increased number to which Camden County is entitled on account of its membership. Alternates elected were Dr. Lester R. Wilson and Dr. J. J. McCarthy. The President announced that the April meeting of the Society will be held in the Camden City Dispensary Building, and that Dr. Frederic J. Quigley, President of the State Society, is expected as a guest.

April Meeting

The regular meeting of the *Camden County Medical Society* was held in the Camden City Dispensary Building, April 3, 1934, at 9 P. M. Dr. T. B. Lee, president, presiding.

Two of the new members elected at the last meeting, Dr. Primas and Wheatland, were introduced to the Society.

Dr. D. F. Bentley, chairman of the Committee on Post Graduate Education, reported the results of the questionnaires sent out to the members on the desirability of having this course this year. The majority favored the afternoon sessions on Wednesday. He also noted the fact that the larger number of the members would subscribe to the Course if it were made at the cost of \$5.00. He felt there would be sufficient members of this Society to subscribe if the cost were \$5.00 to permit them to meet the lecture cost of \$350.00. However, in order to assure that there be no deficit, he suggested that the County Society underwrite the total amount of the lectures as a guarantee. Dr. Lippincott moved that this Society underwrite the cost of the Annual Post-Graduate Series of Lectures for 1934 not to exceed \$350.00. Motion was seconded, voted and carried unanimously.

Dr. T. K. Lewis, chairman of the Emergency Relief Co-ordinating Committee reported that forms would be issued upon which the members would report the amount of E. R. A. work done each month. He emphasized the necessity of having the monthly summaries in the hands of this committee not later than the tenth of the month following work done.

Dr. W. G. Bailey complained that the E. R. A. was not making payments for work done. He stated that he had not received payment for work done in January. Dr. T. K. Lewis replied to Dr. Bailey's complaint by stating the Emergency Relief had been overwhelmed with excessive amount of paper work and was accomplishing payments of vouchers as rapidly as the auditors finished their duties.

A \$1,200 balance in the treasury was reported.

Dr. Robert Sheppard, 768 North 27th Street, Camden, N. J., was proposed for membership.

Dr. F. P. Stone, Tomlinson Avenue, Laurel Springs, N. J., and Dr. C. Sheaffer, 241 E. King's Highway, Haddonfield, N. J., were elected members of the Society.

Mrs. E. C. Pechin, representing the Ladies' Auxiliary to this society, presented, with a few well chosen words, a handsome walnut lectern as a gift to the Society from the Auxiliary. Dr. T. B. Lee, president of the Society, accepted. On motion of Dr. Alex. MacAlister the Auxiliary was given a rising vote of thanks for the gift.

Dr. Frederic J. Quigley, President of the State Society, was the invited guest speaker of the evening. He was introduced to the Society by the president and gave an essay on "The Machinery and Mechanics of the State Society".

Mrs. A. H. Lippincott was granted the floor and questioned the speaker regarding features of the Tugwell bill. Dr. Hummel and Dr. Quigley replied.

Dr. H. F. Palm of Camden, was granted the floor and thanked his friends for their greetings on the recent 79th anniversary of his birth.

The secretary read a communication from the widow of the late Dr. Jos. L. Nicholson, written in appreciation of the flowers sent by the society.

The secretary, also, read a communication from Miller, Mayhew & Thompson, Insurance Brokers, offering a blanket policy covering surgical and scientific instruments against loss by fire, theft, etc. This last communication was humorously commented upon by W. G. Bailey in his usual inimitable manner.

Prior to the regular meeting the Business Committee convened, consisting of Drs. Lippincott, Bentley, Rogers, and Gamon. The following business was transacted:

1. The committee recommended that the Society financially underwrite the post graduate course of lectures. Arrangements were made to have this presented to the Society.

2. A special meeting of the Society was decided upon to be held at Jeannes Hospital in Fox Chase, in June following the meeting of the State Society.

3. The annual combined outing was approved.

4. The Secretary was instructed to write letters to delinquents requesting they make some effort to pay up their annual dues before the end of the fiscal year.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

The society held its quarterly meeting at the Cumberland Hotel, Bridgeton, N. J. Dr. Ray Simkins, President, presided.

Dr. Reba Lloyd, of Bridgeton, extended an invita-

tion to the members of the Cumberland, Salem, and Gloucester Societies to hold the July meeting at her County Sanatorium, Ivy Manor.

Dr. Leslie E. Myatt, Chairman of the society's E. R. A. Committee, reported the results of the joint meeting of the heads of the State E. R. A. and the committee and other workers. The new set-up of the E. R. A. makes it possible for the doctor to obtain permission to give three treatments, then additional treatments to ten or to the amount of \$20 in one month. A flat fee of \$1 is allowed at the office, or \$2 for a home visit of any distance. All bills must be inspected by the E. R. A. Committee of the society. Those obtaining widow's, or old age, or children's pensions must apply to the heads of their respective departments.

Dr. I. W. Knight, of the State Society's Health Committee, discussed the family doctor's rôle in the immunization of the children against diphtheria. If the family doctor is to take part in and get the financial benefits of preventive medicine, he must sell it to the public. The old custom of having the patient come when he is sick will not hold here. The patient must come when he is well. Each physician doing maternity work should advise the mother that she should bring her child for inspection at stated intervals, and that the child should be immunized as soon as it is strong enough to permit. Education must be steadily given. Most of the diphtheria cases occur before the school age, hence the toxoid should be given early. The boards of health should be solicited to furnish toxoid for indigent cases. A clinic hour should be announced when it will be given for a stated sum. Patients unable to pay should be provided with treatment. The rural districts are behind the cities in the campaign.

Dr. H. Lowenburg, of the University of Pennsylvania Post-Graduate School, read and discussed a paper on "Pneumonia and Other Common Infections of Children". The high points were:

The necessity of making a differential diagnosis in the beginning. Pneumonia may simulate acute military tuberculosis, malaria, appendicitis, or meningitis.

The apical type demands especial care. Do not depend too much upon the x-ray to define the condition. The fine art of the old methods is being lost. The younger doctors are too dependent upon the x-ray. The ratio between pulse, temperature, and respiration should be carefully noted.

The tympanitic belly often simulates intestinal involvement. This is due to the toxic effect of the disease upon the nerves controlling peristalsis. Watch the use of milk, for this often increases the condition.

Don't depend too much upon cathartics; alternate them with enemas.

Rest is the prime factor. Don't fuss with the patient, change his clothes or bedding too frequently. "A dirty live person is better than a clean corpse."

Allow plenty of fresh air if the patient tolerates it; cover him up, put on a night cap. If cold air irritates, give him warm air. Cold air does not necessarily mean pure air.

Oxygen is beneficial but should be administered

in a proper tent. The use of tubes is a waste of oxygen and may injure the patient. Improvise a tent from barrel hoops if no tent is at hand.

Such drugs as will compose the patient are the only ones to use. Sera still have a questionable value unless a laboratory is close at hand for typing. Morphine in small doses, without atropine, is the best drug; whiskey is quieting and has some nutritional value.

Artificial pneumothorax is in the experimental stage.

ESSEX COUNTY

Earl Le Roy Wood, M.D., Reporter

The Essex County Medical Society was host for a joint meeting Thursday evening, April 12, 1934, at the Academy of Medicine, Newark, of the First and Second Councilor Districts, comprising the following eight counties: Warren, Union, Morris, Essex, Sussex, Passaic, Bergen and Hudson.

Dr. Edward W. Sprague, President of Essex County Medical Society, after welcoming the visitors, turned the meeting over to Dr. Christopher C. Beling, Councilor of the First District, and Dr. Spencer T. Snedecor, Councilor of the Second District. Dr. Beling introduced the speakers of the evening, Dr. Frank Borzell and Dr. Lyn W. Deichler, both of Philadelphia. These men are eminent members of the Philadelphia County Medical Society and its "Committee to Study Economics". They spoke about current economic problems confronting the medical profession and presented to us "The Philadelphia Recommendations". (Their papers will be published in this Journal—Editor.)

State President Quigley, State Secretary Morrison, State Committeeman Kraker, District Councilor Snedecor, and County Presidents Sprague and Morris participated in the discussion.

In the brief business meeting of Essex County Medical Society that followed the following members were elected:

Regular—Rush C. Bauman, 349 Franklin Avenue, Nutley; Frederick H. Lovell, 1013 Clinton Avenue, Irvington; Henry Simon, 5 Vermont Avenue, Newark; Ruth Boring Thomas, 1 Park Place, Bloomfield.

Associate—Milton Block, 1472 W. Clinton Avenue, Irvington; Adele B. Cohn, 89 Farley Avenue, Newark; Arthur W. Curtis, 399 Lincoln Avenue, Orange; Saul K. Gluckman, 229 Clinton Avenue, Newark; Max Rosenberg, 23 Wyndmoor Avenue, Hillside; Glen L. Yates, 330 Washington Avenue, Belleville.

The Associated Physicians of Montclair and Vicinity

Edwin A. Seifert, M.D., Secretary

The regular meeting of the *Associated Physicians of Montclair and Vicinity* was held at the Essex County Isolation Hospital, Belleville, N. J., Friday, March 23, 1934, at 8:45 p. m.

The association was addressed by L. M. Waugh, D.D.S., F.A.C.D., New York City, Professor of Orthodontia, Columbia University, and Dental Surgeon, U. S. Public Health Service. Dr. Waugh gave an

inspiring lecture illustrated with motion pictures and still photography in color on the subject: "Health of the American Eskimo as Influenced by White Man's Invasion."

In his address, Dr. Waugh pointed out that dental decay was far more prevalent in Alaska after white man introduced quantities of carbohydrate foodstuffs among the natives there.

The Academy of Medicine of Northern New Jersey

A. R. Kristeller, D.D.S., Secretary

The stated meeting of *The Academy of Medicine of Northern New Jersey* held on April 19, 1934, was under the auspices of the Section on Medicine and Pediatrics, of which Jacob Polevski, M.D., is chairman, and Benjamin Saslow, M.D., is secretary.

The President appointed Dr. Charles Zehnder and Dr. Alfred Stahl as tellers. They reported the unanimous election of the following:

Vice-President (2 years), Guy B. Payne, M.D.; Trustees (5 years), Harry B. Epstein, M.D., Francis R. Haussling, M.D.

Committee on Library (3 years), Edgar P. Cardwell, M.D.

Committee on Admissions (3 years), Royal A. Schaaf, M.D.

Dr. Bingham announced that the May meeting would be in honor of Dr. E. J. Ill, of Newark, on May 17, 1934, the eightieth anniversary of his birthday.

The guest essayist, Professor John Wyckoff, Dean New York University, Bellevue Medical College, was introduced. He gave a very interesting discourse on "Ectopic Paroxysmal Tachycardia".

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The *Gloucester County Medical Society* met in the Hotel Pitman, in the Village of Pitman, on the evening of April 19, 1934, with nineteen members present as follows: Drs. E. E. Downs, Duncan Campbell, J. Harris Underwood, H. B. Diverty, Ralph Moore, Fuller G. Sherman, Paul M. Pegau, Harry Nelson and Dorothy Rogers, of Woodbury; Drs. W. J. Burkett, I. W. Knight, Thomas L. Sooy and M. L. Lummis, of Pitman; Dr. Louis Ruttenberg, of Mantua; Dr. Don Weems of Wenonah; Dr. B. A. Livengood, of Swedesboro; Dr. E. L. Ristine, of Westville; Dr. C. I. Ulmer, of Gibbstown, and Dr. H. L. Sinexon, of Paulsboro.

Reports were presented by Dr. I. W. Knight, chairman of the public health committee, and Dr. H. L. Sinexon, chairman of the welfare committee.

Announcement was made that the post-graduate course in medicine would be held at the Camden Dispensary on Wednesdays, beginning April 25. The following physicians will conduct the course:

April 25, Dr. John A. Kolmer, Temple University.
May 2, Dr. Harry Gold, Cornell University.
May 9, Dr. Harry O'Connor, Bellevue Hospital.
May 16, Dr. Bela Schick, New York.
May 23, Dr. Roger H. Dennett, Columbia Hospital.
May 31, Dr. Frank E. Adair, New York.
Dr. F. William Sanderman, associate in medicine

and assistant professor of research chemistry at the University of Pennsylvania, gave a paper on "Some Aspects of Treatment of Diabetes."

Following the meeting the members were joined by the Ladies' Auxiliary for a buffet supper.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held at the Carteret Club, Jersey City, on Tuesday, April 3, 1934. The meeting was called to order by the President, Dr. Daniel B. Street, at 9.15 p. m.

Dr. A. P. Hasking, chairman of the by-laws committee, suggested a change in by-laws to the effect that the polls be open for the October election from 4.00 p. m. to 10.00 p. m., instead of 8.30 p. m. to 10.00 p. m. as formerly. The purpose of this amendment is to avoid the confusion incident to the balloting when but two hours were allowed.

PUBLIC HEALTH COMMITTEE

Dr. R. E. Jaffin gave a report which, he stated, might be taken as part of the Public Health Committee's effort for the current year, emphasizing the anti-tuberculosis work which is being planned for the month of April. To supplement the lectures which were given at the Jersey City Medical Center by Dr. J. B. Amberson, Jr., this committee wishes to carry out an intensive program of Mantoux testing, so that every doctor will be able to do that work himself and leave very few cases for the clinics. By means of illustrative charts, Dr. Jaffin showed that for three years up to 1932, they had been able to do 8,000 children and had found an average of 44 per cent "positive" reactions. He stated that the percentage in school children may be lower.

Dr. Jaffin's purpose in bringing these figures to the attention of the doctors was to show the results of the studies made in the anti-tuberculosis work. The only way he felt that they could combat the problem was to enlist every physician in the effort, and that was the object in bringing the matter before the Society.

He stated that "positive" children should be x-rayed, and the "negative" children examined from time to time, and in that way discover the cases of tuberculosis before they are actually tuberculous. The average case of tuberculosis that seeks the doctor's advice Dr. Jaffin stated, comes to us after the infection has existed for a year. It is up to the physician to find the disease before it is manifest. The plan is that on every Friday at 4.30 p. m., in every city in the county, there will be arrangements made for demonstrating the Mantoux test. At the same time on Friday, there will be some children available in all the clinics, where the test will be given and the technique of doing the test intradermally explained.

Dr. Jaffin also stated that reading and hearing about the test is one thing, and actually doing it is quite another matter. He urged the cooperation of the physicians in doing the work, saying that, if they neglected to do it, another organization would take hold of the matter and then it would

be a case of "state medicine." He concluded by stating that the benefits would not only be to the public, but to the profession as a whole. The Mantoux tests, he announced, would be concentrated at the Jersey City Medical Center, North Hudson Hospital, and the Tuberculosis Clinics in Hoboken, Bayonne, and Kearny.

Dr. Chapman announced that the Annual Dinner would be given on May 2, 1934, at the Masonic Club, at 7.30 p. m. The toastmaster will be Dr. Stanley Woodruff, and the speakers Judge Erwin and Assistant Corporation Counsel Edward Hart.

In the Scientific Session, Dr. J. Lawrence Evans presented the speakers. The program was in charge of members of the North Hudson Hospital Staff, and started with the subject "Injuries About the Shoulder with Presentation of Two Cases of Recurrent Dislocation," by Dr. Alvin Kuhlmann, who showed lantern slides and gave a detailed explanation of the anatomy of the shoulder joint. He also illustrated first aid treatment of injuries about the shoulder joint, showing the methods used, with the material and splints he had on hand. The paper was discussed by Dr. A. Urevitz.

The second subject was the presentation of "A Case of Typhemia", by Dr. Louis Schneider, which was discussed by Dr. C. H. Tannert.

The third case was presented by Dr. A. J. Walscheid whose subject was: "Bleeding from Benign Lesions During and After the Menopause." The discussion was by Drs. H. J. Perlberg and P. D'Acerno, the subject being closed by Dr. A. J. Walscheid.

The meeting adjourned at 11.25 p. m.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Secretary and Reporter

The *Mercer County Medical Society* met in the Trenton Country Club on the evening of April 11, Dr. R. J. Cottone, Vice-President presiding in the absence of Dr. J. A. Connolly, President.

Dr. D. L. Haggerty reviewed in detail recent legislation, and referred in particular to the State Welfare Committee formulating a fee schedule, thereby removing the burden from our own special committee, of which Dr. Sommer is the chairman.

Dr. Wm. R. Little, chairman of the Post-Graduate Course, made a very interesting report relative to the completion of the program and schedule of speakers and subjects, distributing copies and application blanks for registration.

Dr. Samuel Sica, chairman of the Committee on Clinics and Contract Practice, submitted a written report, which was read by the secretary. Following discussion of this report, the motion was carried that each member of the Society receive a copy for study and consideration.

A communication from Dr. A. W. Bingham, chairman of Maternal Welfare Committee of the State Society, was read and referred to the Maternal Welfare Committee of our Society.

Dr. Cottone called upon Dr. Sommer to introduce the speaker of the evening, Dr. Moses Behrend of Philadelphia, who addressed the Society

on the subject of "Acute Inflammations of the Gall Bladder, With Conservative Treatment."

Dr. Behrend detailed a mass of conclusive evidence to support his claims in the treatment of this serious condition. Several interesting films were shown.

MIDDLESEX COUNTY

George F. Hilker, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held at Pfaff's Restaurant, Metuchen, New Jersey, on April 25, 1934. The President, Dr. Joseph Mark, presided, and about 55 members were present.

Dr. William C. Wilentz, reporting for the Medical Arbitration Committee, explained the new ruling of the E. R. A. on doctors' vouchers, in which the total monthly bill must be filled in on form 100, and be signed before a notary.

Dr. Karl Rotschild of the Public Health Committee reported good progress in the campaign for diphtheria immunizations.

Dr. Marshall Smith, Treasurer, reported the Society in good financial standing.

The invitation to the society by Dr. Moletch for a dinner meeting at the Jamesburg Home for Boys was accepted for some date in June. A committee of arrangements was appointed, consisting of Drs. Moletch, Klein, and Wilentz.

Upon motion, it was unanimously agreed to thank Dr. McKinstry for his splendid work at Trenton in getting the Doctors' Lien Bill passed by the Legislature.

A resolution offered by Dr. Clarence J. M. Hofer opposing the extension of E. R. A. fees to other types of patients was read and accepted. A copy of the resolution was ordered sent to the State Board of Children's Guardians at Trenton.

The meeting was then turned over to the Guest Speaker, Dr. A. A. Berg, Chief Surgeon of the Mt. Sinai Hospital, who took as his subject "The Surgical Treatment of Non-Specific Inflammatory Diseases of the Small and Large Intestine". Dr. Berg showed slides of ileitis, and stated that formerly the conditions had been classified as tuberculous, whereas only recently they are being recognized as non-specific inflammatory diseases. He advanced a hypothesis of their etiology, stating his belief that the innervation of the intestinal muscle comes from a brain center which is comparable to the center for striated musculature. Diseases of the center in turn probably sensitize portions of the intestine to the activity of their specific enzymes or bacterial flora, and thus give rise to the varied pathological picture of the non-specific inflammatory diseases.

Dr. Berg gave clinical data in support of his theory. He stated that the results that have followed a wide removal of the sensitized tissue seem to be better than those from a less radical procedure.

Discussion of the topic was given by Dr. F. C. Henry, Jr.; Dr. K. Rothschild, and Dr. J. S. Mark.

The usual light dinner was served, and the meeting adjourned.

MONMOUTH COUNTY

Samuel Edelson, M.D., Reporter

The March meeting of the *Monmouth County Medical Society* was held at the Monmouth Memorial Hospital, Long Branch, New Jersey, on March 28, 1934. President J. E. Maher presided.

The executive committee reported as follows: "The committee first met with Mr. C. H. Oakerson, investigator for the C. W. A. in Monmouth County, to discuss a number of bills which had been submitted. The bills were all passed with one exception and an agreement was reached on this voucher which will be resubmitted and passed in its final form.

On motion of Doctor Stanley Nichols, seconded by Doctor Walter Gosling, a County Welfare Committee was appointed by President Doctor Maher which is to have charge of all legislative matters. The committee consists of Doctor D. F. Feathers-ton, chairman, and Doctors Watkins, Clayton, J. F. Ackerman, and Maher.

After a discussion, it was decided that beginning with the April meeting, the scientific programs would be in charge of a Program Committee composed of Doctor Frank Altschul, chairman, and Doctors Blaisdell, Pons, Weiner, Matthews, Quirk, Kazmann, Holters, and MacKenzie.

It was also suggested that an Economic Committee be formed which would survey and report on the economic conditions and wants of the doctors in the county. The committee is to be more or less permanent, and reports are to be submitted to the Society after a thorough investigation. The President will consider the formation of this committee and will make a report at a later meeting.

It is reported from the office of the Executive Secretary, Doctor LeRoy A. Wilkes, that C. W. A. cases may be attended by school physicians and others under the new ruling. The treatment of C. W. A. cases does not come under the E. R. A. agreement with the County Medical Society, but is handled by the E. R. A. personnel under the Federal Compensation Bureau, and no reduction in standard prices is expected for this type of work.

A suggestion was made by Doctor Fisher to appoint a committee to consider the advisability of holding county meetings at some place other than the hospitals. He felt that certain members of the society did not attend county meetings because they had no staff appointments.

Doctor Oscar Hyer was elected to membership.

Doctor Frank Overton, Editor of the State Journal, and Doctor LeRoy A. Wilkes, Executive Secretary of the State Society, were present at the meeting. Doctor Overton spoke concerning the news items and papers which are being submitted to the Journal, and commended the reporters for their excellent accounts of the meetings. Doctor Wilkes spoke of the various legislative procedures which were being handled by his department.

The Society was addressed by Doctor N. Ransohoff, orthopedic surgeon to the Monmouth Memorial Hospital, Long Branch, New Jersey. Doctor Ransohoff's paper was "Tendon Transplantation and Stabilization for Paralytic Weak Foot." Following Doctor Ransohoff's paper, Doctor Victor

Knapp, gastro-enterologist to the Monmouth Memorial Hospital, spoke on "Peptic Ulcer."

The following was the program of the Clinical Conference of the Monmouth Memorial Hospital, April 11, 1934.

1. Doctor Rullman presented a case of Exophthalmic Goiter which had been operated by Doctor Hagerty and later by Doctor Crile. Adrenal bilaterally sympathectomy and thyroidectomy.

2. Doctor Kazmann: Gas bacillus infection. Frequency of diabetic gangrene complicated by gas gangrene.

3. Doctor Maher: Neoplasm of ascending colon. Ileo-colostomy and removal of growth.

4. Doctor Knapp: Staphylococcus Septicemia.

5. Doctor Holters: Agranulopenia associated with the ingestion of amidopyrine.

6. Doctor Fisher: (a) Scarlet fever complicated by mastoiditis; (b) Ludwig's Angina—Dissection of fascial planes—Recovery.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A special scientific meeting of the *Morris County Medical Society* was held the evening of Tuesday, March 27, at the State Hospital at Greystone Park.

President J. F. Frost presided, and about eighty-five members and guests were present, including members of nearby county societies.

The speaker of the evening was Dr. Paul B. Magnuson, of the Northwestern University, Chicago, Illinois, a foremost traumatic surgeon, whose subject was "The Surgical Treatment of Certain Types of Arthritis", illustrated by slides and motion pictures.

Introducing the speaker, President Frost referred to Dr. Magnuson's association with the celebrated surgeon, Dr. John D. Murphy, who was the first to dictate while operating, describing what he felt and thought while operating.

Dr. Magnuson said that he was strongly of the opinion that the general practitioner knows more about arthritis than the specialist; and that he was not an arthritis specialist, but has been trying for a number of years to find out how to help some of the arthritic patients to get well. He described the various types—rheumatoid, atrophic, hyperthrophic, and degenerative—and the diagnostic difficulties, x-ray evidence of arthritis always being ancient evidence. By means of slides, the speaker showed and explained various joint conditions. He also used moving pictures to show a complete operation, explaining it in detail from the incision and exposure of the joint to the removal of all pathology and the closing of the wound. At the end of the reel was shown a post-operative patient with good use of the knee joint that before operation was rigid and useless.

Discussion was impressively led by Dr. Clay Ray Murray, of the Fracture Department of Presbyterian Hospital, New York, who emphasized the point that, no matter what he found on surgical procedure of an arthritic or simulating condition, if by the removal of all pathological findings the patient be restored to economic health and activity, even for five or six years, it is that much

gained over so many years of uneconomic existence and treatment.

Dr. Elmer P. Weigel, orthopedic surgeon of Plainfield in the neighboring county of Union, said that he did not know of any one subject more interesting in bone and joint work than this arthritic subject. Speaking of the rheumatoid type, he described his success in attacking the first joint involved, with the result that the others quiet down and show a good deal of improvement. He concluded that surgery can play a larger part in the future than it has in the past in this field.

Dr. G. H. Lathrope, of Newark, presented the medical side of arthritis.

Refreshments were served after the meeting.

A special meeting of the *Morris County Medical Society* was held the evening of Thursday, April 19, 1934, at All Souls' Hospital in Morristown; this being the third of a series of intra-society clinics.

The setting and arrangements for the meeting were ideal and scientifically the program upheld the high standard and indicated the painstaking efforts so characteristic of these stimulating endeavors of the local talent.

President J. F. Frost announced a limit of 15 minutes for the presentation of each subject with discussion limited to two minutes for each participant.

The proceedings opened with "Surgical Jaundice" by Franklin W. Rice, of Morristown, who stressed the diagnostic difficulties in the average case, and the importance of avoiding careless application of ligatures. He said that from the laboratory viewpoint, it is absolutely imperative that the patient's condition be thoroughly worked out before operation is indicated; and cited an instance of a surgeon against whom was rendered a verdict of \$10,000, and a lot of embarrassment. Important points were illustrated by graphs, including methods of producing stricture and jaundice by the misplacing of ligatures, and the correct method of their application. Discussion was entered into by Drs. Rubin, Abrams, Christian, Frost and others.

"Carcinoma of the Transverse Colon" by Bernard C. McMahon, Morristown, was the next presentation. Doctor McMahon detailed an unusually interesting case. He showed the specimen which had been removed, and stated that the patient, a prominent and busy lawyer, is at this time in normal health and has gained 30 pounds in weight.

Discussion was taken up by Drs. Abrams, Rubin, Troedsson, Conitas and Christian.

President Frost's contribution was "Pathology of the Genito-Urinary Tract with Pyelograms," with verbal explanations during the showings. Methods of treatment were detailed, and discussions followed.

"A Case of Polysystic Kidney" was presented by W. A. Falvo, illustrated by pyelograms and specimen passed around for inspection.

"Staphylococcus Aureus" was presented by D. Woolsey Teller, Morristown, with x-rays, the speaker described an interesting case of a boy of

13 years of the athletic type, with blood transfusions and other treatments given. Interesting discussion followed which was led by Drs. Larson, Christian and Nicoll.

"A Case of Meningitis with Exophthalmos" was presented by Doctor Harris, of Morristown, and Doctor W. B. Gibb, of Madison, the latter devoting himself, in harmony with his specialty, to the exophthalmic phase, and which probably had no definite bearing upon meningitis. This subject elicited considerable discussion, prominent in which were Drs. Troedsson, Larson, Rice, Krauss and Christian.

There were about 45 present and with the conclusion of an intensely interesting program, refreshments were served.

President Frost announced the next meeting would be in May at The State Hospital, Greystone Park, and admonished the members not to forget the annual meeting of the State Society.

SALEM COUNTY

William H. James, M.D., Reporter

The regular meeting of the Salem County Medical Society was held at the Hospital in Salem on Wednesday evening, April 11, at 9 o'clock, with President William T. Hilliard presiding.

The regular business of the meeting was conducted in the usual manner, after which the society had the pleasure of hearing a paper by Dr. E. E. Evans, Chief of the Medical Department of the Dupont Dye Works at Deepwater, N. J., on the subject of "Industrial Medicine".

This was one of the most interesting papers ever brought before the society. The doctor described the hazards of the various chemicals made at the plant, and the means to protect the 4000 workmen while employed.

Dr. Le Roy A. Wilkes, Executive Secretary of the State Society, was present and gave a short talk on the work of the various legislative committees and what they were doing in Trenton for the medical profession.

Dr. Frank Overton, the Editor of The Journal of the State Society, said that he hoped to make The Journal practical so that every member of the State and county societies could enjoy reading it.

At the conclusion of the meeting, the society enjoyed a luncheon in the main dining room of the hospital.

The next meeting will be the annual social session at the Country Club, where the famous planked shad dinners are enjoyed.

SOMERSET COUNTY

J. L. Young, Reporter

The regular meeting of the *Somerset County Medical Society* was held at the Walker-Gordon Certified Milk Farm in Plainsboro, N. J., on April 12, 1934. The Society was the guests of the Woman's Auxiliary.

The following members were present: Drs. Renner, Flynn, Knight, Piggott, Adams, East, Field, Stilwell, Ely, Flint, Francis, Cooper, Brittain and Sferra. The meeting was called to order at 12:30

p. m. by Dr. Flynn, presiding in the absence of the President, Dr. McConaughy.

Dr. Lancelot Ely, Chairman of the Medical Advisory Committee of the E. R. A. and C. W. A., rendered a report of the activities of that committee.

Resolutions in reference to the death of Dr. Allis were read. The committee consisted of Drs. Field, Meigh and Stillwell. The resolutions are as follows:

"In the sudden passing of one of our colleagues, Dr. Jerre A. Allis, from our midst, the Medical Profession of our county has suffered an irreparable loss.

"Active in the practice of his profession as School Physician, as Veteran of the World War, he made many friends and was held in high esteem by all.

"We wish to express our deep sense of regret at the loss to our Society, to the county, and to his family.

"Resolved, that a copy of this resolution be spread upon the minutes of this Society, a copy published in the local press."

Dr. D. S. Renner, Chairman of the Educational Committee, spoke on the Rutgers Post-Graduate Course to be held soon. He proposed a mixed course, one most likely to appeal to more members. His suggestions were endorsed and Dr. Renner promised an announcement of the program at an early date.

A letter from Dr. Mahaffery was read, wherein he offered to send Dr. A. J. Casselmann of the United States Public Health Service and consultant to the State Department of Health, to address our society on "Coöperation in the Treatment and Control of Venereal Diseases". The Secretary was instructed to accept Dr. Mahaffery's offer.

The Society's attention was called to the fact that our county society does not have a Welfare Committee. Heretofore all legislative matters were left in the hands of individual members and particularly in the hands of the Secretary. Dr. Ely informed us that several years ago we had a Legislative Committee, i. e., a welfare committee. He moved that such a committee be appointed, and that it work hand in hand with Dr. A. A. Lawton, who is a member of the State Welfare Committee. The motion was carried and the following committee appointed: Drs. F. L. Field, J. H. Cooper, W. B. Gray and A. F. Sferra.

The business meeting then adjourned and the members joined the Woman's Auxiliary as its guests to luncheon.

Following the luncheon, there was a tour of inspection of the Walker-Gordon Farm.

UNION COUNTY

Russell A. Shirreffs, M.D., Reporter

A regular meeting of the society was held at Muhlenberg Hospital, Plainfield, on the evening of April 11, the President, Dr. W. B. Morris, presiding. We were fortunate in having as the guest speaker Dr. Harrison Martland, Associate Professor of Forensic Medicine, New York University and Bellevue Medical College, and Medical Examiner of Essex County, N. J. His topic was "The Causes of Sudden Death", the lecture being illustrated by many lantern slides.

The following physicians were elected to membership: Drs. Charles F. Wood, 175 Central Avenue, Westfield, N. J.; Sydney S. Pearl, 815 Kilsythe Road, Elizabeth, N. J.; C. Gustave Hunson, 15 Alden Street, Cranford, N. J.; G. E. Obester, 617 Madison Avenue, Elizabeth, N. J.; Rosarin J. Maggio, 200 Ross Place, Westfield, N. J.; Edward J. Callahan, 640 E. Broad Street, Westfield, N. J.

Delegates and alternates elected were:

Delegates—3 years: J. B. Harrison, Westfield; H. H. Bowles, Summit; S. T. Quinn, Elizabeth; H. V. Hubbard, Plainfield; C. H. Schlichter, Elizabeth. Two years: E. S. Krans, Plainfield; J. Reiner, Elizabeth; E. Stein, Elizabeth; Elmer Weigel, Plainfield; W. B. Morris, Springfield. One year: E. W. Lance, Rahway; R. J. Walsh, Roselle; M. L. Ripps, Elizabeth; C. A. Brokaw, Elizabeth; H. E. Abel, Elizabeth.

Alternate Delegates—3 years: L. H. Leggett, Westfield; Maynard Bensley, Summit; S. H. Davis, Plainfield; G. Knauer, Elizabeth; A. R. Casilli, Elizabeth. Two years: J. J. Runnels, Scotch Plains; H. Bloch, Elizabeth; J. Blumberg, Elizabeth; J. J. Labow, Elizabeth; R. T. Blythe, Cranford. One year: A. J. Drury, Roselle; J. W. Currie, Plainfield; Harold Johnson, Plainfield; W. Phelan, Elizabeth; E. J. Carlin, Roselle.

Alternate for member of Nominating Committee: E. S. Krans, Plainfield.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The Warren County Medical Society met at Baker's Inn, Washington, on the evening of April

17, 1934, with the following members present: Drs. Bloom, Bossard, Baldauf, Curtis, Krausz, Mills, Shimer, Skinner, Varner and Veres. Guests present were Dr. Homer Bloom, Victor Messinger and R. E. McLaughlin from Easton; Dr. W. H. Harmon from Hackettstown; Dr. D. P. D. Jackson from Belvidere; Dr. W. E. Auer from Washington; and Dr. LeRoy A. Wilkes, Executive Secretary of the State Medical Society. The President, Dr. Emory Krausz, of Phillipsburg, presided. Dr. William F. Skinner was appointed Secretary pro tem.

Resolutions of respect on the deaths of Drs. Charles B. Smith and Frank McKinstry were read and approved and ordered spread upon the minutes, and copies sent to the bereaved families.

Dr. Lawrence Bloom made a report on the post-graduate course. It was voted not to hold the course in Warren County this year. Dr. Bloom also gave a report on the Public Health Program.

Dr. W. H. Harmon, of Hackettstown, and Dr. D. P. D. Jackson, of Belvidere, were elected to membership.

Dr. LeRoy A. Wilkes, Executive Secretary, gave an interesting talk on legislation, and various other activities of the State Medical Society.

Dr. Frank W. Curtis, of Stewartsville, was elected as delegate to the State Medical Society to fill the unexpired term of the late Dr. Charles B. Smith.

Dr. R. E. McLaughlin, Chief of the Dental Department of Easton Hospital, then gave a very interesting paper on "Oral Sepsis as an Etiological Factor in Systemic Diseases", which was discussed by Dr. Messinger and Dr. Auer.

The meeting was followed with a lunch.

Obituaries

DR. THOMAS F. BURNETT

Dr. Thomas F. Burnett, former city physician of Elizabeth, died on April 2, 1934, at his home at 279 South Pleasant Avenue, in Ridgewood, after an illness of several months. Although living in Ridgewood, he had maintained offices in Elizabeth for many years.

Born in Elizabeth in 1869, he was the son of the late Captain Thomas Francis and Elizabeth Burnett. He received his early education in the New Brunswick schools, and his medical training at Bellevue Medical College, New York, from which he was graduated in 1893. He started the practice of medicine in Elizabeth and continued it until the time of his death, serving several years as city physician.

Dr. Burnett represented several insurance companies in his work, and also the Elizabeth Lodge of Eagles, Court Robert S. Green, Independent Order of Foresters, Elizabeth, and Elizabeth Lodge of Elks, of which he was a member.

DR. GEORGE F. WILBUR

Dr. George Franklin Wilbur, senior member of the Monmouth County Medical Society, died on April 1 in his home at Asbury Park.

Dr. Wilbur was born June 8, 1856, at Hightstown, N. J. He graduated from Princeton University in 1879, and from the Medical Department of the University of Pennsylvania in 1882.

A resident of Asbury Park for fifty years, Dr. Wilbur was well known in the shore section. He served as a member of the Board of Health six years, and was school physician about twenty years. He was a member of the American Medical Association, and President of the New Jersey State Board of Medical Examiners six years.

Dr. Wilbur was an active member of several fraternal orders, including the Masons, and the Odd Fellows.

His son, Dr. Franklin L. Wilbur, practices medicine in Asbury Park.

DR. CHAUNCEY BOYD GRIFFITHS

Chauncey Boyd Griffiths, M.D., F.A.C.S., a prominent gynecologist on the staff of the Hospital

for Women and Children, Newark, N. J., died in that hospital on March 23, 1934, after an illness of over a year. He was born in Newark on October 17, 1869, and graduated from the College of Physicians and Surgeons of Columbia University in 1896. He returned to his native city in 1898, and at once he became a member of the staff of the Hospital for Women and Children, becoming it chief of staff and a trustee. He was active in medical organizations, both local and national, and in civic work. He leaves a widow, two sons, and three grandchildren.

DR. WILLIAM F. HOELER

Dr. William Francis Hoeler, 808 South Eleventh Street, Newark, N. J., died in his home on April 8, 1934, from a heart attack. He was born in 1881, and graduated from the Maryland Medical College, Baltimore, in 1908. He was a member of the Essex County Medical Society and a Fellow of the American Medical Association. He was also a member of several fraternal and benevolent orders, including the Foresters, Woodmen, and Elks, and also of the Holy Name Society of St. Ann's Church.

Communications

THE NEW JERSEY GASTRO-ENTEROLOGICAL SOCIETY, INC.

J. Gercandasy, M.D., Secretary

The New Jersey Gastro-Enterological Society held its quarterly Scientific meeting at the Academy of Medicine, Newark, N. J., on Monday, March 26, 1934.

Dr. Martin E. Rehffuss of Philadelphia spoke on "The Duodenum as a Major Clinical Problem". He then reviewed the physiology of the stomach, dividing this organ into the fundic portion (four-fifths) where the glands secrete pepsin and hydrochloric acid, and the distal third where the principal secretion is mucous for lubrication and protection. This portion may also secrete a hormone which stimulates the fundic glands. The pyloric region is also the motor segment of the stomach, important chiefly in the chymification of food.

The factors concerned in the excitation of gastric secretion are the cephalic (physic), the mechanical and chemical stimuli of food in the stomach, and lastly the intestinal phase where stimuli acting on the small bowel cause gastric secretion.

He then described briefly the function of the pylorus and its relation to duodenal regurgitation. He believes that the pyloric function is intimately related to the gastric peristalsis. In this conception it is impossible to dissociate the duodenum from the stomach since the "cap" of the duodenum forms the residual part of the antral contraction. It is probable that the state of fullness of this part of the duodenum is a factor in pyloric function, especially in the automatic regulation of the gastric acidity. The acid fluid irritates the intestinal wall, provoking antiperistalsis, which drives the alkaline secretion of the intestines into the stomach, resulting in the lowering of the gastric acidity.

A study of the normal individual's response to food shows that from a secretory standpoint three groups are noted: 1, a hypersecretory group (rapid secretion of acid); 2, an isosecretory group (moderate but sustained secretory curve with a gradual fall); and 3, a hyposecretory group, (slow and low secretion). He also brought out the fact that, from a motor standpoint, there are normal fast and normal slow stomachs, depending on the rapidity or slowness of food evacuation.

The gastric digestive cycle he divided into adjustment, acme, and readjustment periods, as indicated by poor food admixture, digestive work, and falling off in secretory activity, respectively.

He ended the presentation with numerous lantern slides illustrating the points, as well as the many experimental data he had performed over a period of years to substantiate his theses.

The discussion was opened by Dr. Burrell B. Crohn of New York who spoke of the clinical value of such investigations as performed by Dr. Rehffuss. He stressed the almost constant presence of hypersecretion and hyperacidity in duodenal ulcer, and the reverse in gastric ulcer. He also stated that in subtotal gastric resection in duodenal ulcer the acidity persists and therefore arises the liability to the formation of gastro-jejunal ulcer; while after resection for gastric ulcer this complication is very rare. He contrasted the chronicity and liability to recurrence of duodenal ulcer with the ease of healing of gastric ulcer; also the possibility of malignancy in the gastric, and its entire absence in the duodenal ulcer.

Dr. Crohn believes that removing foci of infection (such as teeth) has no appreciable influence on the healing or recurrence of ulcer. He also stressed the familial tendency in duodenal ulcer, several members in the same family being affected. He indicated with lantern slides the predominance of complications (hemorrhage and perforation) in the Libman subsensitive individual, as contrasted with the normal or hypersensitive patient.

Drs. Polevski, Stein, Johnson, Kaplan discussed the paper briefly.

The annual meeting of the Society will be held in conjunction with the meeting of the State Society, Wednesday, June 6, 1934. There will be an informal dinner and a general get-together. The work of the past year will be reviewed, and plans for the new year outlined. There will also be an election of officers for the ensuing year.

The society hopes to have a scientific session in conjunction with the State Society at its annual meeting in 1935.

THE ANNUAL MEETING

Auxiliary Day! What is it? When is it to be? Please read every word of this letter, and then act.

The Woman's Auxiliary is preparing for a day so full of interest and pleasure for every doctor's wife who may read this, that you should not miss it. The important day for the women during the three days of the State Medical Convention, will be Wednesday, June sixth.

The day is drawing near for our Annual Meeting in Atlantic City, and the last time I shall have the honor of serving you as President of the Auxiliary. I hope you will realize that the success of this meeting as well as the whole work of the Auxiliary depends upon the interest and efforts of the wife of every doctor throughout the state. I wish I could impress upon every one who reads these words that, if she is not there, she will detract from the pleasure of all who are there. We shall miss her so much, and our work for the medical profession and her husband's business particularly will suffer materially. She will also

lose a great deal herself. One cannot come in contact with a group of such exceptionally fine women as attend our meetings without being broadened mentally, socially, and in every way.

Whether or not you are a member of the Auxiliary, come to the Garden Room of Had-don Hall for the morning session, which is the important event of the day, June sixth.

Be sure to attend the luncheon. It has always been one of the most pleasant and long remembered parts of our annual meetings.

The crowning event of that day's pleasure will be the President's Banquet and entertainment. You will enjoy it and will meet many old friends.

In closing, I thank the women who have been active members, workers, and officers throughout the state during my term in office. I am proud to be numbered among you. It is through your efforts the work of the Auxiliary has been carried forward this year.

Viola B. Hubbard,
President.

THE PLACE OF THE AUXILIARY

The Woman's Auxiliary to the Medical Society of New Jersey has component Auxiliaries in exactly two-thirds of the counties of the state, but these counties contain 85 per cent of its population. It is only natural that the larger counties should contain a greater proportion of trained leaders, and should offer a larger field of Auxiliary service than the smaller counties which have fewer facilities for organization.

The Journal maintains a department devoted to the activities of the Auxiliaries, especially those of the counties, and will print the accounts of all meetings of which reports are received.

A feature of the meetings of the auxiliaries in many, if not most counties is that they are held in connection with those of the County Medical Societies, each body holding its own session, and all the members joining in a social luncheon. The auxiliary therefore performs an essential service to medicine in promoting that kindly feeling which is at the basis of all efficient relations among physicians.

This same plan will be adopted for the coming meeting of the State Auxiliary. The ladies will hold their own organization assembly on Wednesday morning and will entertain the physicians at a noon luncheon and after-dinner speaking.

The Auxiliary will come into its own on Wednesday evening when it will sponsor the Official Dinner Dance which is a feature of the annual meeting of every state medical society. The dinner will be an opportunity for each lady to observe the friendly interest that is sure to be shown to her husband by his professional colleagues, for the fraternal spirit is strong among doctors. The ladies will do much to promote that brotherhood which will be one of the most valuable results of the annual meeting.

The program of the Auxiliary is printed in full on page 299 of this Journal, together with the names of the leaders whose object will be to assist the physicians and their wives to enjoy not only the dinner but also the entire annual meeting of the State Society.

AUXILIARY COUNTY SOCIETIES

Atlantic County

Mrs. Violet S. Mason, Chairman

During the year of 1933-34 the Atlantic County Auxiliary did not attempt to have set programs, having found from previous experience that it was impossible to get members out to hear speakers and so forth.

The meetings were held every month alternating in the afternoon and evening, the evening meetings being held at the same time and place as the men's meeting. These evening meetings were not well attended.

In the afternoons business was discussed, followed by cards and refreshments. These meetings were well attended.

Atlantic County

Reported by Mrs. Manuel Malley.

A regular meeting of the Woman's Auxiliary to the Atlantic County Medical Society was held in Haddon Hall on Friday evening, April 13, 1934, at eight o'clock. Mrs. Joseph Poland, President, presided.

The question of the Copeland-Tugwell Bill was brought up. We had requested an opinion from the Atlantic County Medical Society as to whether they approved of the Auxiliary sponsoring a public meeting where Mr. Howard Arbruster would speak against the Copeland-Tugwell Bill. We received a reply stating that the Medical Society had decided to support this legislation, so it would be out of order to have Mr. Armbruster speak against it at a meeting under our sponsorship.

Mrs. Louis Rosenberg reported that our Spring luncheon would be held at the Claridge Hotel on Wednesday, May 9, at one o'clock.

The following delegates were appointed to the Convention in June: Mrs. Carl Surran, Mrs. Lawrence Wilson, and Mrs. W. Blair Stewart; alternates, Mrs. Edward Guion, Mrs. John Massey, and Mrs. Manuel J. Malley.

The following officers were elected for the coming term:

President, Mrs. James North.
First Vice President, Mrs. Carl A. Surran.
Second Vice President, Mrs. Daniel C. Reynier.
Treasurer, Mrs. Robert A. Bradley.
Recording Secretary, Mrs. Lawrence A. Wilson.
Corresponding Secretary, Mrs. Manuel J. Malley.

Mrs. James North, the newly elected President, announced the following committees for next term:

Publicity, Mrs. James J. Mason, 3rd.
Program, Mrs. Samuel Salasin.
Public Health, Mrs. Louis Rosenberg.
Entertainment, Mrs. David B. Allman.
Public Relations, Mrs. John Massey.
Hygeia, Mrs. Percy Clark Joy.
Widows and Orphans, Mrs. E. H. Harvey.
Membership, Mrs. W. Blair Stewart.
Telephone, Mrs. Herman Kline.
Charity, Mrs. Wm. Roop.

Mrs. Poland introduced the guest of the evening, Mrs. Viola B. Hubbard, President of the Woman's Auxiliary to the Medical Society of New Jersey. Mrs. Hubbard suggested that we utilize the speakers available to educate the lay people of our community in public health. She asked our support in all favorable legislation pertaining to the medical profession, and explained something of the sterilization bill, and its advantages.

Bergen County

During the year 1933-1934, our Auxiliary held regular monthly meetings each of which had an educational program as well as a business meeting.

At our first meeting in October, Miss Dorothy Stephens, Chief Dietician of Post Graduate Hospital, New York City, gave a talk entitled, "To Dine or to Diet."

In November Miss Louise Zimmerman, District Supervisor of Mid-Wives, Bureau of Child Hygiene, State Department of Health, spoke to us about "The Progressive Mid-Wife."

In December we attended the open public health meeting given by the Medical Society, at which Dr. W. H. Park, Director of Laboratories of the New York City Department of Health, spoke on "The Public Health Aspect of Diphtheria." and Dr. Stanley Nicols, on "The Public Health Program of the Medical Society of New Jersey."

January brought us a speaker on "Pre-School Training and Education," while in February, Miss Cadwalder, of the State Department of Health, spoke to us on "The Prevention and Control of Venereal Disease."

In March we had a most delightful speaker, Dr. Janet Miller, member of the Staff of Bergen Pines, whose topic was "Experiences in The Belgian Congo."

At our April meeting, we were specially fortunate. we had an interesting speaker on "Newer Things in Nutrition." We then joined with the Medical Society to hear Dr. Bernard Sachs, President of the New York Academy of Medicine and Consulting Neurologist whose topic was "This Oversexed World."

Instead of our annual card party, this year we are having individual ones given by various members during the month of April, and hope they will prove even more financially successful than the one large party.

This year we started a philanthropic fund to be used for the families of needy physicians, and we stand ready to give help at the call of our Medical Society.

Another innovation was the starting of a raffle at each meeting. Some inexpensive article is raffled, and the winner of it must donate an article to be raffled at the following meeting. The money thus realized goes into the philanthropic fund.

During the year, at the request of the State Medical Society we sent telegrams and letters to our Assemblymen and Senators urging the passing of the "State Doctors' Title Bill" and the National "Pure Food and Drug Bill."

Through our Public Relations Committee we are sponsoring a contest in the first year of the high school for which prizes of \$10 and of \$5 are to be given for the best 150-word essay on the topic "Diphtheria Immunization to Promote Public Health."

We had one executive meeting during the year, and in May will hold our Annual Luncheon and Election of Officers.

Respectfully submitted,
(Mrs. S.) Flossie K. Alexander,
Park Ridge, N. J.

Burlington County

Reported by Mrs. M. M. Schisler

Mrs. G. E. McDonald presided at the regular meeting of the Women's Auxiliary to the Burlington County Medical Society, held at Boxwood Lodge, Lumberton, N. J., on March 7, 1934.

Mrs. Harry V. Hubbard, State President, was our guest. Twenty-five members and six guests were present.

A short business meeting was held.

A report was given by Mrs. J. E. Davie on "Hygiea."

Mrs. L. Hartman and Mrs. G. E. McDonald were chosen delegates to attend the "Health Program" to be held at the College of Physicians and Surgeons at Philadelphia.

The report of the Secretary and Treasurer was read and approved.

Luncheon was served at 1.30 p. m. This was followed by a musicale.

Meeting of the executive board of the Burlington County Women's Auxiliary was held at the home of Mrs. Howard Hornberger on March 21, 1934. Plans were started for the Reciprocity Tea to be held in the Community House, Moorestown, N. J., at 2 p. m., on May 2. Two hundred and fifty invitations were sent out. The meeting adjourned and tea was served by Mrs. Hornberger.

Hudson County

Reported by Caroline Culver

The regular monthly meeting of the Woman's Auxiliary to the Hudson County Medical Society was held on the afternoon of Monday, March 5, at the Y. W. C. A. building in Fairmount Avenue, with the President, Mrs. Frank P. Nicholson, in the chair.

The Corresponding Secretary reported letters sent to our Senators in relation to the Pure Food and Drugs Act; she also reported having received answers from the legislators.

One new member was welcomed, Mrs. Trehwella, Sr.

It was moved, seconded, and carried that we have a small and informal card party on the 19th of the month, with Mrs. Peter Maras as chairman, in order to raise funds for charity work.

The high point of the afternoon was reached when Mrs. Nicholson presented our ex-Presidents, Mrs. William Freile, Mrs. John Nevin and Mrs. George M. Culver, with the lovely County Auxiliary

pins, making a pleasing speech as she gave them out.

Dr. B. T. D. Schwarz was to have been the speaker to explain to us the Widows' and Orphans' Relief Fund, but due to illness in the family we had to change our plans. Mr. William Christy, smoke abatement engineer of Jersey City, came to our rescue and gave use an interesting and instructive talk on the smoke nuisance. We demand pure food and pure water; why not pure air? Smoke does millions of dollars worth of damage every year besides being detrimental to health, but with regulations and coöperation it can be abolished, no matter what kind of fuel is used.

He spoke especially of the Brunswick Laundry, which burns many tons of coal with never a bit of smoke to annoy their neighbors.

Much discussion followed his talk; and as almost everyone had a smoke grievance of one kind or another, Mr. Christy was kept busy telling the members how to go about making their complaints.

The usual social hour with tea followed, when Mrs. Maras, as chairman of hostesses, was assisted by an able committee.

The Woman's Auxiliary to the Hudson County Medical Society held its annual Spring tea at the Y. W. C. A., Fairmount Avenue, on the afternoon of Friday, April 6, when guests from many of the clubs and societies of the county were present.

A short business meeting preceded the program, with the President, Mrs. Frank P. Nicholson, in the chair. One new member was welcomed.

The chairman of Entertainment Committee gave a short report on the recent card party, which had been a great success.

It was voted to put \$50 of the proceeds into the savings account and the balance in the checking account.

It was moved, seconded and carried that we hold our Spring play-day at the Arcola Country Club on Tuesday, May 25, with a luncheon and cards. Mrs. Charles B. Kelley, chairman of entertainment, will be in charge, assisted by Mrs. Peter Maras.

Mention was made of the Spring meeting of the Executive Board of the State Auxiliary and plans were made for the State Convention in Atlantic City June 5, 6 and 7.

Among the special guests for the afternoon were our State President, Mrs. Harry Hubbard, of Plainfield, and Mrs. Frederick Kinch, of Westfield, a member of the State board.

Governor A. Harry Moore was the guest-speaker for the afternoon. In his talk, he touched upon many subjects, beginning with the problems of the many industries in the state. Branching off, he spoke briefly of the state institutions and of the many men who had been willing to sacrifice themselves in the cause of science. Governor Moore held the close attention of the ladies for nearly an hour and he was given a rising vote of thanks for his kindness in coming and giving us this interesting and entertaining talk.

The tea table was a picture of springtime loveliness, with jonquills, pink tulips and yellow candles. Mrs. Dodson, chairman of hostesses, served the tea, assisted by a group of the younger members.

Somerset County

Mrs. Esther A. Levy, Reporter

On Thursday, April 12, a meeting of the Woman's Auxiliary to the Somerset County Medical Society was held at the Gatehouse of the Walker-Gordon Certified Milk Farms at Plainsboro. The Medical Society also met at the same time, so that the members of the Medical Society could join the Auxiliary at luncheon following the meeting, as guests of the Auxiliary. There were 33 members present.

The regular business of the organization was transacted. The following officers were elected unanimously for the ensuing year: Mrs. Ely, President; Mrs. Stillwell, President-Elect; Mrs. Adams, Vice-President; Mrs. Flint, Treasurer; Mrs. Barbour, Corresponding Secretary; Mrs. Halstead, Recording Secretary and Reporter.

The following Delegates and Alternates were elected to attend the State meeting: Mrs. Ely, Alternate Mrs. Meigh; Mrs. Stillwell, Alternate Mrs. Adams; Mrs. Renner, Alternate Mrs. Pigott.

The following tribute was read in memory of Mrs. Mabel Probasco McConaughy, one of our members and wife of Dr. Francis McConaughy, President of the Somerset County Medical Society:

"On Palm Sunday, March 25, 1934, Mrs. Mabel Probasco McConaughy, a valued member of the Auxiliary to the Somerset County Medical Society and wife of the President of the society, passed quietly out of this life. Mrs. McConaughy's passing leaves a vacant place in the ranks of the organization which cannot be filled. Hers was an attractive, happy personality. Her fine sense of humor and winsome manner made her an ever-welcome participant in the Auxiliary gatherings. She was interested in all that pertained to her husband's profession, both in the home and in the community, the real significance of which only a physician's wife can understand.

"We, her fellow members in the Auxiliary, desire to record our appreciation of all for which she stood, and our keen sense of loss at her passing.

"This tribute to her memory is presented at a regular meeting of the organization, and it is resolved that copies be sent to Dr. McConaughy, his son, the State Journal, and that a copy be incorporated in the minutes.

“(Signed) Adaline W. Stillwell,
Alice L. Ely.”

Following the luncheon, a tour was made of the Walker-Gordon plant under the direction of Dr. Hardenbergh. The rotolactor was seen in action and its mechanism was explained to the guests.

Union County

Reported by Mrs. George Seymour

The annual meeting of the Woman's Auxiliary to the Union County Medical Society was held in the Nurses' Home of the Muhlenberg Hospital Wednesday evening, April 11, while the County Society met in the hospital. Eleven members were present. One new member, Mrs. C. Knapp, of Elizabeth, was welcomed. Mrs. H. Bowles, the President, was in the chair.

The Treasurer, Mrs. Laird, reported a balance on hand of \$97.28; in the Students' Fund, \$39.75.

Mrs. C. Schlichter, chairman of Nominating Committee, presented her report in which Mrs. F. Gilpin, Cranford, was suggested for President-Elect; Mrs. P. Bunting, Elizabeth, Vice-President; Mrs. A. Hoover, Elizabeth, Director; Mrs. G. Seymour, Elizabeth, Secretary. These nominees were elected.

Plans for social activities and business program for Auxiliary members attending State Medical Convention in Atlantic City was reported by Mrs. Bowles.

A letter from Dr. Quigley, President of State Medical Society, regarding the Doctors' Title Bill, was read by our President. After some discussion, the Secretary was instructed to write a letter to our Senator and Representative, urging their support on the passage of this bill.

Following the meeting, Mrs. H. Corbusier, of Plainfield, in her usual charming manner, gave a delightful and interesting talk on her recent cruise through the West Indies and South America, which was enjoyed by all present.

Dainty refreshments were served to the ladies by the Superintendent of Muhlenberg Hospital in the Nurses' Dining Room.

Ocean County

Reported by Mrs. E. M. Sickel

The regular meeting of the Woman's Auxiliary to the Ocean County Medical Society was held at the home of Mrs. Robert Halbach, Toms River, on the afternoon of Friday, April 20, 1934, at 2:15 o'clock.

The following committee reports were made: Mrs. Robert Buermann, Chairman of the Public Health Program Committee, reported that work had been started to contact the County Health Department in an effort to establish definite plans for assistance to be rendered by the Auxiliary.

Mrs. Fred Bunnell, Chairman of the committee on "Hygeia", reported that seven schools had been furnished with the national magazine this year.

It was decided to make plans for a card party to be held in early June at the Toms River Yacht Club, the proceeds to be given to the Paul Kimball Hospital. Mrs. Frank Brauwer, of Toms River, was appointed chairman in charge.

Mrs. Woodhouse discussed a letter from the State Society urging that we make use of a list of prepared *Health Talks*, each written by a physician prominent in his field. These talks are especially well adapted to radio addressing of the public. Since broadcasting stations are not easily available to us, the use of the talks discussed as a possibility for daily and consistent publication in local newspapers contributed and sponsored by the Auxiliary.

There was election of officers and the following were chosen:

President: Mrs. Alfred Woodhouse, Toms River.
Vice-President: Mrs. Eugene Herbener, Lakewood.

Treasurer: Mrs. Robert Halbach, Toms River.

Secretary: Mrs. Emanuel Sickel, Lakewood.

These officers were named delegates to the Annual State Convention in Atlantic City.

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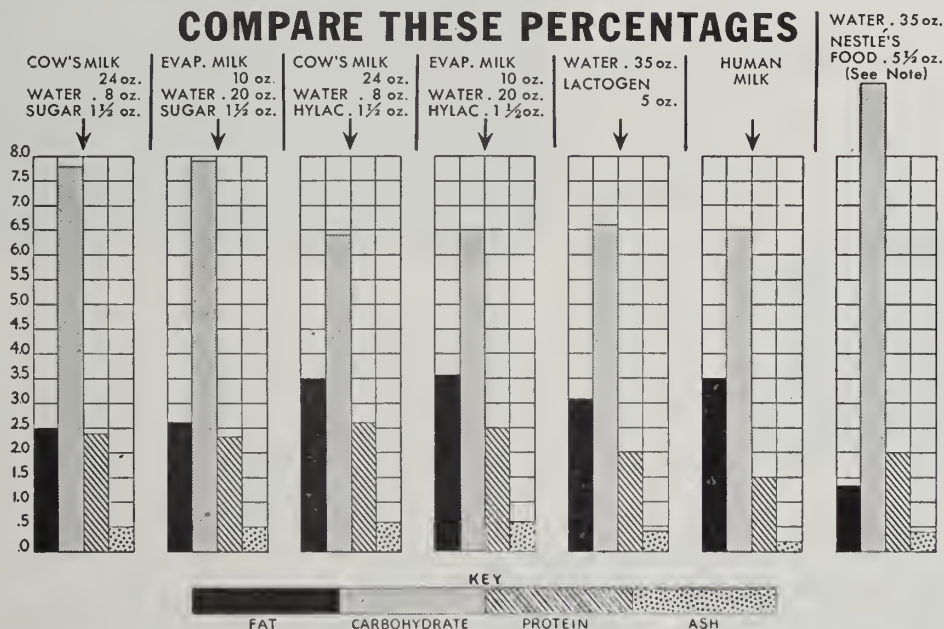
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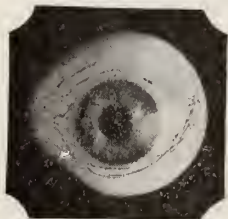
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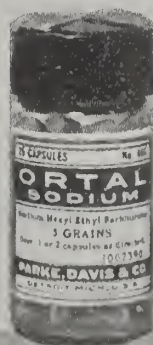
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THE E. R. A. IN LOUISIANA

That the E. R. A. is not working entirely to the satisfaction of the doctors of Louisiana is shown by correspondence in the February issue of the New Orleans Medical and Surgical Journal. Mr. H. J. Early, Executive Director of the E. R. A. wrote to Dr. C. A. Weiss, President of the Louisiana State Medical Society on December 23, 1933:

"It is beginning to look as if we must limit our parish offices in the matter of medical fees. There is at present a tendency to overcharge.

"Are you willing for us, without your approval of the schedule itself, to broadcast to our relief director flat rates which we can pay, pending an agreement with you?"

Dr. Weiss replied on December 24:

"The steps you suggest in your letter do not require the sanction or consent of the Louisiana State Medical Society, however, I beg to again remind you that with the coöperation of the Louisiana State Medical Society, you will be assured of the best medical and surgical care of the indigent sick under your directorate. Without this sanction and support, the members of organized medicine throughout the State may not be inclined to manifest a very deep interest in the matter.

"That the physicians were really worse off than the recipients of relief, due to the fact that they

have given their all to the support of the relief of the indigent sick, and were too proud to apply for relief for themselves and their dependents. This sad condition exists in some of the States in which the physicians had agreed to accept the lower fee schedules.

"Organized medicine stands ready and willing to do its part in helping you carry out this part of the program and asks only a fair consideration."

On December 30, Mr. Early replied:

"My suggestion is that we, the Medical Society and the Emergency Relief Administration, agree to put the schedule recently revised by us into effect January 1st for a ninety day period, with the express understanding that the rates are temporary and that if a higher schedule can be adopted for the whole southern area, of which Louisiana is a part, we will revise the temporary rates to the higher schedule, and change to become effective on the first of the month following the adoption of the higher or permanent schedule."

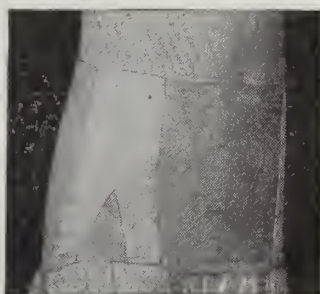
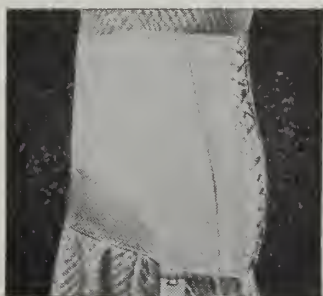
The account of the correspondence closes with the following paragraph:

"Subsequent to the receipt of the above communications, telephone communication between our President and Mr. Early resulted in Mr. Early taking the position that he would not authorize any medical schedule other than that which he had submitted."

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APPROACH



VIEW OF THE GROUNDS

BOOKLET AND TERMS ON REQUEST

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WHAT IS "ADEQUATE" MEDICAL CARE?

The Pennsylvania Medical Journal of December, 1933, gives the following summary of what the Medical Advisory Committee of the E. R. A. of Pennsylvania considers to be adequate medical care.

"First: A brief recorded history of the illness with special emphasis on the time and manner of onset, and the development of symptoms from the time of onset to the time when first seen by the physician.

"Second: A physical examination such as lies easily within the reach of every physician (made and recorded for inspection, if necessary, by the Local or State Medical Advisory Committees). This should include temperature, pulse, respiration; and examinations of the ears and throat in all children ill from any cause so as to rule out acute ear infections and tonsillar infections as the cause of the symptoms. At least one chest examination should be made with the chest properly exposed, auscultation of the heart, blood pressure in the majority of instances, and an examination of the exposed abdomen. All patients with symptoms referable to the rectum should have a digital examination. A vaginal examination need not be routine, but should always be made in the event of menstrual irregularities at any age and if there are symptoms referable to the pelvic organs. A

urine analysis should be routine. Blood count should be optional. A Wassermann test, if indicated, will be made by the State Laboratory, free of charge.

"Most errors in diagnosis are made, not from lack of ability, but on account of failure on the part of the doctor to have necessary clothing removed for a complete examination."

CODE OF ETHICS OF HOSPITALS

The January issue of Colorado Medicine presents a brief code of ethics of the Colorado Hospital Association. This code deals with the same conditions as that of the American Hospital Association, which may be abstracted as follows:

Publicity as to quality of work done implies unusual ability and efficiency by its doctors; and is an advertisement of the members of the staff and therefore savors of quackery.

Publicity of ability to give service that is better than other institutions is advertisement for self-aggrandizement and is misleading.

Publicity of statistics in reports and drives for funds is permissible; provided superlatives and comparisons are avoided.

Publicity of an institution should be such that will tend to develop confidence in other medical institutions.



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Supplement to The Journal of The Medical Society of New Jersey, June, 1934

This sheet is to replace pages III and IV of the "Official List of the Fellows, Officers, Delegates and Members of The Medical Society of New Jersey, prepared by J. Bennett Morrison, Secretary, assisted by the Secretaries and Treasurers of the County Societies". Page IV of the Official List issued in May, 1934, is incorrect.

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"The protest of the District Medical Association of Woonsocket against the ill-advised establishment of outside agencies, and in charge of outside physicians, of various clinics, the latest by the Mental Hygiene Society, should receive the hearty support of their colleagues. If it seems to anyone that a need for such clinics exists in any community, obviously the first move should be to seek the advice and coöperation of those who have been bearing the burden, the local profession, by a direct appeal to their organization, the district society. While making no claim to perfection, and while realizing their obligation to work constantly for the best interests of their fellow-citizens in all matters pertaining to health."



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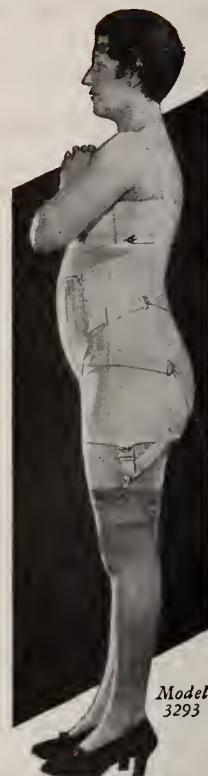
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



EDITOR OF
THE JOURNAL
FRANK OVERTON, M.D., Dr. P.H.

OFFICES OF THE SOCIETY—137 EAST STATE STREET, TRENTON, N. J., TEL. 9330
EXECUTIVE SECRETARY—LEROY A. WILKES, M.D.

Each member of the State Society is entitled to receive a copy of THE JOURNAL every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly. Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor. Officers, Trustees, Councilors and Committees of the Society are listed on page xxii of the Advertising Section.

VOL. XXXI, No. 6

JUNE, 1934

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EDITORIALS

Greetings from the Incoming President

At the end of a year of *achievement* and the beginning of a year of *possibilities*, your incoming President extends his greetings. May we have a year of thoughtful planning and close coöperation. May it be a year of prosperity to each member, and of success to our State Society.

It is encouraging to note the increasing medical and surgical activities in the different county societies. The bulletins and announcements sent out by their secretaries are up-to-date programs on the practice of clinical medicine, indicating that, while we are considering our economic problems, we are not neglecting our scientific work.

The method of practicing medicine has been undergoing a change in the period within the memory of even the youngest practitioner, and much has been said of the trend toward "state" medicine when every doctor will be working for a salary. If the doctors of New Jersey will continue to develop the system of coöperation indicated by the Emergency Relief Administration and the Public Health Hour, the public's criticism of the doctor and the agitation for a change of system will cease, because the

doctors will have met and suggested relief for the problem before its solution was forced upon them. New Jersey has gone further than any other state in developing a practical system of medical service for all its people. Further progress will depend upon the action of the State Medical Society, and the hearty coöperation of its members.

If we believe in the slogan "Medical Problems for Medical Men", let us willingly coöperate with the recommendations of the Public Health Committee and be ready to institute and promote all efforts for modern diagnosis and treatment. State departments of health and allied associations and lay organizations are ready to coöperate in such work, but its inception should be the work of the medical man.

It will be my object as President to protect the doctor in his private practice, and to perfect it in fields in which the coöperation of the community is required. Let me appeal to you as members of your county society, to take an active part in your medical organization, for *it needs you*.

LANCELOT ELY.

Consult the County Medical Society

There is a health element in nearly every welfare movement, and the physician is the first person to whom an appeal is made in all health programs. Strength and vigor, grace and beauty are emphasized in every movement relating to outdoor life, character building, moral training, and education for citizenship. A medical advisor is included in the personnel of every summer camp, boy scout troop, welfare group, and industrial club. Every county has its semi-social organization whose very existence depends on medical service in some form. The physician is expected to supply this service voluntarily and to support these movements to a greater extent than any other professional man. It is to his credit that he makes a double response—as a citizen with his money, and again as a physician with medical service.

The entrance of lay organizations into the field of medical service during the last decade has given rise to new problems. New adaptations of medical services, and new interpretations of the code of medical ethics and of time-honored methods of medical procedures seem likely. Sufficient experience has now been accumulated to indicate methods by which the two groups of health workers—the physicians and the laymen—may provide an effective coordination of their services with efficiency and satisfaction.

Physicians have often complained that they could not get the cooperation of their patients or the public in the fields of prevention, and of the treatment of chronic conditions. But lay organizations are now available to aid physicians in fields in which they have formerly been limited. For example, it takes a nurse or a welfare worker, or a governmental board to provide the means by which the poor tuberculous patient may rest and submit to treatment knowing that his family is receiving the means of support which he is too weak to provide.

Lay health workers and members of the medical profession have sometimes been involved in misunderstandings and disputes because they have approached the problem of the delivery of medical service from opposite directions.

POINT OF VIEW OF LAY WORKERS

Lay workers have seen patients suffering from physical incapacities and diseases in the midst of an over-abundance of available medical service. The trouble has not been the lack of physicians willing to provide medical service; the deficiency has been in the means of its *distribution*.

The assertion has sometimes been made that the medical profession has been apathetic, and unresponsive to these conditions. The truth is that it has always been the pride of every practitioner of medicine that he has responded to every worthy call for his services. The physician who does not voluntarily observe this basic requirement of his profession soon abandons the practice of medicine to take up some other occupation.

The supporters of lay health organizations have been prone to assume that, when they have pointed out a need for a particular form of health service, physicians would voluntarily supply it and the people would put it to efficient use at once. They have sometimes expected to accomplish

“Something noble and grand and good

Done by merely thinking we could.”

The lay workers have often confused the *object* of their organizations with the *means* and *methods* of the delivery of the services. A lay person can see unfulfilled needs for medical service; but only physicians can understand the practical difficulties and limitations in supplying those needs.

THE ATTITUDE OF PHYSICIANS

Physicians understand the futility of methods which are spasmodic and temporary. They have little faith in measures which are devised by the inexperienced and are presented to the medical profession for immediate adoption. Doctors have small faith in the sudden *creation* of new forms of services; they believe in the *evolution* and further *extension* of the older forms that have been proved to be adapted to mental processes and habits of the people.

Physicians approve the widespread interest

shown by lay health workers. The interest of these laymen has been aroused by practical leaders among the physicians in private practice who have realized the vital need of the assistance of the lay workers. Each group is now ready to agree upon a practical method of developing the newer fields of medical practice.

THE ATTITUDE OF THE MEDICAL SOCIETY OF NEW JERSEY

The Medical Society of New Jersey represents the physicians of the State, for 2750 of the 4000 practicing physicians of New Jersey are *active* members of the State Society. They pay dues to support its work, and serve on committees to devise practical methods of improving medical services which are now imperfectly delivered.

The organization of the State Medical Society is duplicated in every one of the twenty-one counties of the state, each of which is a component society, having committees which are similar to those of the State Society. This machinery exists for enlisting every physician in New Jersey to put into effect a comprehensive plan of action in civic projects of a medical nature.

PRINCIPLE OF ACTION

The principle of action which has been adopted by the physicians of New Jersey is that of *voluntary coöperation* with other health organizations. The health projects which require promotion are numerous; but the State Society with the approval of the County Societies has chosen *diphtheria immunization* as one of its major objectives, and the "*Public Health Hour*" as the means of attaining that object.

THE PUBLIC HEALTH HOUR.

The physicians of New Jersey at their Annual Meeting in 1933 decided that the most practical means of securing universal protection against the dread disease of diphtheria is through immunization; and that every physician shall actively participate in the project by immunizing all who need the service. The phy-

sicians offer their services to three classes of patients:

1. Those who can pay the regular fee for the immunization.
2. Those who can pay a special reduced fee.
3. Those who are not able to pay any fee.

For classes two and three they will set aside a *Public Health Hour* in their offices according to a plan which is described in an editorial by the Executive Secretary of the State Society (see page 318).

The plan will relieve the lay organizations of the burdens of supporting free clinics, and will make every doctor's office a "Medical Center" where the lay workers may send those who need the immunizations.

The "Public Health Hour" is the answer of the physicians of New Jersey to the allegation that they are unwilling to adapt their methods to the new conditions of modern life. It is a provision for those who otherwise might not seek these services.

EDUCATING LAY WORKERS

A necessary step in coöperation is the education of the lay workers. Heretofore, it has been their custom to approach a few individual physicians regarding a new health project which they plan to establish in a community. The proper step in every instance is first to consult the officers of the County Society.

When a physician's approval of a plan is sought, the proper reply for him to make is "Consult the committee of the county medical society or its nearest branch organization". It is surprising that the people generally, and even lay health workers, are often unaware of the existence of a county medical society whose representatives are ready to advise them in regard to their public health projects. The time has passed when a community health project can be promoted by the independent action of individuals. Success will come when health workers turn first to the representatives of the County Medical Society for advice and guidance in planning health projects.

The Public Health Hour

Prevention when practically applied and demonstrated to be effective is obviously desirable, and can best be achieved by those whose training and experience especially fits them to provide the necessary service.

The actual prevention of unnecessary illness and death requires a medical training and experience in directing the people and ministering to their needs. The ability and will to utilize such advice and service in order to benefit most depends upon the individual. The organization and supervision of these efforts by trained administrators increases their effect and benefits the greatest number of people.

The vast majority of trained *executives* in the Public Health field are experienced physicians who specialize in Public Health Administration. They are by law held responsible for the control of environment hazards to health and have broad police power, though they use this only as a last resource.

The private physician is an *advisor*,—not a policeman. Yet with our present-day knowledge, he can protect through immunization and vaccination a person who might otherwise prove to be a danger to himself and others. But such a person must first be advised where to seek the services of a physician, or else be sent or brought to him by a public health nurse or through other community agency.

The *Public Health Hour* offers to the public the opportunity for certain preventive services at a low cost, and denies to no worthy individual this protection solely because he cannot pay for it, though every effort will be made to prevent the continuance of the prevalent abuse of free services intended for indigent persons.

The problem of the "chronic" indigent must be better solved in the future if taxation is to be kept within bounds and self-support is to be encouraged. As a nation, we must either accept our individual responsibilities and discharge them faithfully, or we must pool our resources and distribute them according to some practical plan not yet devised. We cannot operate successfully under two diametrically opposed philosophies and policies.

A practical equality of man—either physi-

cally, mentally, or morally—is yet to be demonstrated, in spite of our idealism.

Greed is still evident in high places, and obedience is still compelled and not voluntary in a minority that cannot be ignored.

Voluntary coöperation between individuals and agencies established for the common good has at times proven a practical solution, and offers considerable hope for the solution of many of our problems in medicine,—and elsewhere. Domination by individuals and nations is eventually lost, and samples of the aftermath are now in evidence on all sides. Governmental ownership and control may be desirable in extremities, but as a solution of many of our present ills it has yet to be proven a panacea.

The survival of the fittest, or "Rugged Individualism", still has its advocates; but many fine persons are not rugged enough to prevent their own exploitation, and many others are only rugged enough to protect themselves. We shall, however, probably require a sufficient number of individuals who are rugged enough to become leaders.

"Am I my brother's keeper?" The physician has in part endeavored to be, as far as health protection and restoration are concerned. But many brothers seem unappreciative, and some are even selfish when the physician most needs help.

In a world where truly "no one liveth unto himself alone", the negligence and misfortunes of one person effect others in spite of their own care and diligence. Unworthy and selfish individuals must often be protected by the worthy in order to protect themselves. This is true both in communities and nations, and the expense for *this* type of care should be shared by all.

The Medical Societies in each county of New Jersey are organizing to provide a "Public Health Hour" in the office of each physician. Some physicians who specialize may not be able to offer this service, but they will be glad to indicate a nearby physician who will provide it.

Lists of participating physicians are already available in many counties, and the other coun-

ties are now compiling their lists. The State Department of Health has agreed to furnish toxoid and vaccine for the use of physicians in their "Public Health Hour" in order to secure wide-spread protection of the children of New Jersey.

An emergency appropriation for toxoid and vaccine is available until July 1, 1934, but provision for the next fiscal year awaits legislative appropriation. As soon as the Legislature reconvenes on June fourth, funds will be sought to insure the continuations of this work after July first, when the new fiscal year begins.

No provision for toxoid was officially made in the 1934-35 budget, as the Joint Appropriations Committee claimed that no enabling legislation existed when this committee was considering the Health Department budget for 1934-35. The passage of A-373 and its approval by Governor Moore on May second provided the enabling legislation for appropriations in future Health Department budgets; but this legislation was not in effect

when the budget for 1934-35 was approved by the Joint Appropriation Committee and sent to the Legislature. When toxoid and vaccine for 1934-35 are made available, the Public Health Hour project will get into full swing.

The State Department of Health will announce the *distribution centers* in which the toxoid and vaccine are to be obtained, and will require the reports as to its use which are mandatory by law. Blanks for these reports will be furnished by the State Health Department, together with the toxoid and vaccine to all physicians who agree to provide in his office a "Public Health Hour" at least twice a month and to conform to the agreement made by the State and Component County Medical Societies to provide service at \$1.00 per injection in the Public Health Hour, and to provide free service to those whom the physicians believe to be indigent.

LEROY A. WILKES,
Executive Secretary.

Original Observations

The reports of proceedings of county medical societies reveal a wealth of original observations regarding diseases—their prevalence, causes, diagnosis, and treatment—which are worthy of preservation. Opportunities for making these observations are not confined to the greater medical centers, nor to the larger research laboratories. They exist in every community, no matter how small it is. A classic example is that of the disease, Huntington's chorea, which was first described by Dr. George Huntington, in 1871, in his thesis on graduating from the College of Physicians and Surgeons, New York. He used the case reports of a peculiar disease which his father and grandfather had accumulated during a medical practice of seventy-five years in Easthampton, a community of about 1000 people, on the eastern end of Long Island.

The chronic mouth infections popularly called sprue or thrush offer a field of investigation. A district state health officer in close touch with the physicians of a rural section

investigated a series of these cases and enlisted the interest of the Research Laboratory of New York City. The point was made by the workers in the laboratory that these and similar conditions are usually brought to the attentions of research workers by rural physicians, and that research into their nature is extremely desirable.

New Jersey has a number of community hospitals which are, in fact, medical centers, equipped with the facilities to make detailed observations and tests, and having local staffs of physicians to whom all the cases in the hospital are known. An example of the opportunities afforded by these centers is that of the series of observations on vitiligo reported on page 339 of this Journal. The natural course to follow in reporting these cases is to present them at a meeting of a county society or other recognized group of physicians. The approval of the members will be the credentials for the acceptance of the articles for publication in The Journal.

THE PHILOSOPHY OF THE MEDICAL SOCIETY OF NEW JERSEY

THE ADDRESS OF THE PRESIDENT

By **FREDERIC J. QUIGLEY, M.D.**, Union City, N. J.

Delivered before the Medical Society of New Jersey at its Annual Meeting, June 6, 1934,
in Haddon Hall, Atlantic City

There are many matters of interest and concern to this Society which I should like to discuss in this address, but the limitations of time and of your patience, perforce, constrain me to restrict myself. An even more impelling reason for confining myself as to subject-mat-

THE PHILOSOPHY OF THE PRESENT POLICY OF THE SOCIETY

Following the World War, as the result of a variety of causes, there have been changes in the government or form of government of many of the leading countries of Europe. In our own country there was a psychological reaction to the high pitch of two years of war-time effort, a desire for a let-down and a return to "normalcy", which expressed itself in the "Harding land-slide" of 1920 and the ushering in of a "conservative" administration which endured for a period of twelve years.

We are all familiar at least with the immediate cause of the reaction of the citizenry of our nation, which, in large measure, was responsible for the election of President Roosevelt in 1932. The nation had had twelve years of a supposedly conservative administration, a period of unparalled prosperity; then three years of economic depression of increasing magnitude, with an apparent inability on the part of the Federal administration to cope successfully with the situation.

We realize now that the whole philosophy of this period was unsound; perspective, and the sense of proportion and of values were distorted and blunted.

The reaction in our national government has been a sharp swing to the left. Whether this swing will become even more pronounced, or a more moderate policy develop, can not, at the moment, be foretold. That there is grave danger to Medicine in the light of the present trend can not be gainsaid.

There is a certain similitude in the policy and administration of the Medical Society of New Jersey during the past twelve or thirteen years to that of the National Government during that period.

In the year 1920 the infamous Chiropractic Act was passed by our State Legislature. Within a year 597 chiropractors were licensed



FREDERIC J. QUIGLEY, M.D. 153

*President of The Medical Society of New Jersey
1933-1934*

ter is the apparent imminence of a crisis in the affairs of Organized Medicine. At this critical juncture, the question of policy becomes the dominant and over-shadowing issue. I shall therefore limit myself to a discussion of two topics:

1. The philosophy of the present policy of the State Society.
2. National planning and policy to meet the threat of State control of Medicine.

by the newly created State Board of Chiropractic Examiners.

Just as the length and severity of the present depression has thrown into sharp relief the handicaps and inequities of present day practice and aroused in the profession a compelling sentiment for an active constructive policy on the part of the Society, so did the passage of the Chiropractic Act in 1920 awaken in the members a militant spirit and a demand for remedial action.

Dr. Wells P. Eagleton, to whom this Society owes more than it can ever repay, at this time conceived the idea of the Welfare Committee. He became its first chairman, serving in the years 1921-22, and during 1923, the year of his presidency of the Society. During this period under the chairmanship of Dr. Eagleton, the Welfare Committee was successful in repealing the Chiropractic Act and in passing the "Limited License Act". The Workmen's Compensation Act was liberalized, and the limit of \$50 for medical and hospital care removed. Also an Act was passed which drove out of the State the many "cult" schools then infesting it. All of these measures directly benefited the profession.

To accomplish these legislative results required intensive effort and a gearing up of the Society to a high pitch. Innumerable meetings of the Welfare Committee were held; one, two and sometimes three trips were made weekly to Trenton by the Legislative Sub-committee during the legislative sessions. County society officers were called upon to organize their units, to interview and endeavor to gain the support of their legislative representatives. Members of component societies were impetioned to write their legislators. Frequent large demonstrations were staged in the State House at Trenton; the night the "Limited License Act" was passed, 1000 members were present in the Assembly Chamber.

This brings us to the years 1924-25. The majority of the major legislative objectives of the Society had been attained. The rank and file of the profession were busy with their individual practices and were making a good, or at least a comfortable, living. They wished to

be let alone; to have a surcease from the demands of the Society.

In response to the apparent wishes of the majority of the membership, a change of policy was inaugurated and a more conservative administration ensued. We passed through the halcyon days of 1927 to 1930 like the rest of our fellow-countrymen, making and spending money freely. Everyone was happy and contented; there was no wish nor desire on the part of the Society for a change from the now well-established policy of conservative administration.

During the first two years of the depression, with "the wish father to the thought", relying somewhat perhaps on the pronouncements of the leaders of our national Government and others that the depression would soon be over, and that "prosperity was just around the corner", we continued our policy of laissez-faire.

I would not wish to convey or create the impression that it is my opinion that no progress was made by the Society during this period. Neither do I wish to imply that it is my belief that the fine group of men who were my predecessors in the office of President were lacking in purpose.

Progress *was* made. One of the outstanding accomplishments during these years was the successful efforts to democratize and liberalize the Society, culminating in a complete revision of its Constitution and By-Laws.

A State-wide plan of post-graduate medical courses was projected and has been successfully continued. While no legislation was passed during this time for the benefit of the doctor, no inimical public health or cult legislation became law.

The present policy of the Society, as I interpret it, is merely a beginning answer to the present desire, expressed and unexpressed, of the rank and file of the profession to ameliorate their present plight and improve the conditions of medical practice.

We all recognize that the fungi and barnacles we are now attempting to dislodge from the Practice of Medicine are excrescences which enjoyed luxuriant growth in the immediately passed era. It took three years of depression with rapidly waning incomes to

rouse the profession from its apathy, its indifference and unconcern, to a realization that, for the policy of drift and inaction, there must be substituted a policy of planned and energetically sustained action if the present predicament of the profession is to be improved.

My conception of the primary function of the Medical Society of New Jersey is that it is to promote and conserve the interests of the doctor; not the drones, or the incompetent, but the great mass of our membership—intelligent, able doctors—who are striving, day in and day out, to render good, and still better, service to the public.

The Society has other purposes, the chief of which is, as expressed in its Constitution: "In general, to render the profession most capable of serving humanity." This, its highest purpose, cannot be fulfilled unless the interests of the profession are made the primary concern of this organization: that the profession remains untrammelled; that the incentive for scientific advancement and special training is stimulated and retained; that the conditions surrounding the practice of Medicine make it possible to practice it as a profession and not as a trade; that it offers an opportunity of a decent living. If the status of the doctor is not maintained at a decent level, the quality of medical service will be impaired; Medicine will not continue to attract students of the type that has made ours the noblest of professions; and the highest purpose of this Society: "to render the profession most capable of serving humanity" will become a meaningless declaration, impossible of fulfillment.

NATIONAL PLANNING AND POLICY TO MEET THE THREAT OF STATE CONTROL OF MEDICINE

It matters not that this Society is developing a definite policy and program to meet problems peculiarly State in character; it matters not that its officers, committees and members are assuming their joint responsibilities in working out these problems; *unless* the parent body of Organized Medicine—the American Medical Association—immediately assumes its responsibility of leadership to meet the great-

est threat that has ever been made to American Medicine: the menace of control of Medicine by the State—all our efforts, whatever progress has been made by the Society, will have been in vain and a nullity.

I shall at this point read a copy of two letters written by me to Dr. Olin West, Secretary of the American Medical Association; one in December of last year, the other, last month (May 1934).

"December 16, 1933

"Dr. Olin West, Sec'y,
"The American Medical Association,
"535 North Dearborn St.,
"Chicago, Ill.

"Dear Dr. West:

"I am impelled to report to you some interesting and disturbing information that has come to my notice. Within the past two weeks, a responsible individual close to the welfare group headed by Mr. Hopkins, Federal Relief Administrator, and Miss Perkins, Secretary of Labor, in conversation with the Chairman of the Public Health Committee of our State Society, stated that the present Federal administration is working on a plan of compulsory health insurance, which it will launch sooner or later. This information, I believe you will agree, if true, is important. Besides the credibility of the source of it, various social theories projected by the present administration make me feel that this proposal fits in with the general pattern of the social program now being advanced.

"Is the American Medical Association in a position to state what the Federal Administration's attitude is, or will be toward medical practice? If the attitude of the Administration is unknown, do you not think it expedient that some responsible officer of the Association sound out the President and ascertain, if possible, his views?

"The majority of organized medicine of this State, at the moment, are opposed to compulsory health insurance. It is my impression, however, that an increasing number favor the plan, undoubtedly due in largest measure to the precariousness of their income as a result of the long depression and to an increasing

realization of the handicaps—or in the language of the “Codes”, the unfair competition—besetting present-day practice. Considering the present financial plight of such a large proportion of the population and the insecurity of the rank and file of the profession, I seriously question, if a pronouncement were made by the President of the United States advocating a subsidized form of medical practice, whether it would be possible to check the movement.

“Assuming that this possibility may soon be an actuality, has the American Medical Association any program or plan prepared to meet the situation?

“An identic letter is being forwarded to Dr. Dean Lewis, President, and Dr. W. C. Woodward, Director, Bureau of Legal Medicine and Legislation.

“Very truly yours,

“(Signed) FREDERIC J. QUIGLEY, M.D.,
“President.”

“May 22, 1934

“Dr. Olin West, Sec’y,
“American Medical Association,
“535 North Dearborn St.,
“Chicago, Ill.

“Dear Dr. West:

“May I suggest that, in connection with this letter, the correspondence and telegrams exchanged between us from December 16th, 1933, to January 15th, 1934, be reviewed?

“Both you and Dr. Dean Lewis, President of the Association, replying to my identic letter of December 16th, 1933, gave assurance * * * * *.

“In my letter of December 16th, you will note that I mentioned having received reliable information that the Federal Relief Administrator, Mr. Harry L. Hopkins, and Miss Perkins, Secretary of Labor, had stated ‘that the present Federal Administration is working on a plan of compulsory health insurance which it will launch sooner or later.’

“At a meeting of the Advisory Council of the Millbank Memorial Fund, March 15th, 1934, Mr. Hopkins, Federal Relief Administrator, who was present, according to the New York Times of March 16th, is quoted as having made the following remarks:

“‘You aren’t going to get health insurance,’ Mr. Hopkins said, ‘if you expect people to do it voluntarily. I am convinced that by one bold stroke we could carry the American people along not only for health insurance but also for unemployment insurance. I think it could be done in the next eighteen months.’

“In the usually reliable and well-informed New York Times of Friday, May 18th, 1934, a news article dealing with the permanent plans of the President, under the heading ‘Social Insurance Studied’, contains the following:

“‘Insurance against sickness is known to appeal deeply to the President, and the recommendation, should he decide to make it at this time, will represent ideas he has been working out for several years. He is believed to favor a system based on compulsory contributions by employers for the benefit of their employees by the establishing of “sickness reserves” as the proposed unemployment insurance provides against periods of industrial depression.

“‘Compulsory contribution for sickness insurance, while favored by some social service workers, is opposed by others who advocate, instead, expansion of the present system of medical care on a public welfare basis as more flexible and with wider possibilities of usefulness.’

“In a news article in the same paper, May 20th, 1934, under the caption ‘President Shapes a Lasting New Deal’, is the following:

“‘The permanent program, as differentiated from the expedients, contains three main aspects, * * * :

“‘1. The social program—expected to be outlined in a message to Congress on the eve of adjournment and embracing adjudication of labor disputes, Federal unemployment insurance, national old-age pensions, *nation-wide insurance of workers against sickness* (italics ours); a Federal housing program, establishment of a permanent public relief system, and amendment of N. R. A. provisions to bring minimum wages into line with costs of living.’

“With this evidence before us, one can not escape the conclusion that the projection of a national health insurance scheme or plan is imminent.

“You will recall that I asked your permis-

sion to reprint in our State Journal your letter of December 18th in reply to mine of December 16th. In view of the fact that it contained matter, the publication of which might prejudice certain negotiations of the A. M. A., then under way at Washington, you specifically requested that it be not published.

"Inability to make public your letter prompted me to publish in the January issue of our State Journal a short editorial, entitled 'Cause for Reflection'. May I invite your attention to it? It deals with the trend toward compulsory health insurance; the two concluding paragraphs are:

"Some of our present methods of medical care very likely will be modified in the future—perhaps in the near future. Are our national leaders in the medical profession planning constructive measures to meet situations that may arise? Mere opposition to proposed plans is not sufficient.

"A national policy and a national program are necessary. Forty-eight plans from as many states will not do. We must be prepared for concerted action when the time comes."

"This exactly expressed my viewpoint at the time; I am more firmly convinced today than ever that this is the only way by which this problem can be successfully met.

"I feel that the majority of the members of organized medicine of this State are in accord with the stand of the A. M. A. in opposition to compulsory health insurance, as recommended by the majority of 'The Committee on the Costs of Medical Care'. However, the A. M. A. recognized and approved the recommendations contained in the minority report of this committee.

"The 'Minority Report' contained certain definite recommendations to meet present-day medical practice. It has been my own feeling that the A. M. A. should formulate a broad-gauge general plan, which, while adhering to principles which we believe vital and sound, would meet the changed social conditions of the day.

"With the talent available at A. M. A. headquarters and with the coöperation of leaders of medical thought throughout the country at

its command, it would seem entirely possible to work out such a plan.

"From the standpoint of strategy, the group taking the offensive—providing the plan and tactics of the offensive are sound—usually places itself in an immediately advantageous position.

"It may be contended that, with the autonomy exercised by State Societies in the control of their own affairs, such planning is not feasible. I do not believe this to be true. An emergency exists, and I believe that it is possible to secure prompt authorization of the majority of State Societies, either through action of their respective Executive bodies or their Houses of Delegates in special session, for the A. M. A. to proceed with the formulation of a uniform plan to meet the situation.

"It is my thought that, after such plan or program is formulated, it be submitted to the executive bodies of all component societies. The *action* of the A. M. A., to be decided by the result of this referendum.

"I should appreciate your prompt reply and permission to use your letter in my Presidential Address, to be delivered at our Annual Meeting, June 5th.

"Very sincerely yours,

"(Signed) FREDERIC J. QUIGLEY,
"President."

Dr. West promptly replied to my letter of May 22, 1934, his answer being received the 25th. While I am unable to give you the contents of his letter, I do not believe I shall be guilty of any breach of privilege, in quoting three of the concluding paragraphs:

"As I have already intimated above, I am of the opinion that it would be neither wise nor desirable to print this letter, for the following reasons:

"1. It might be a serious mistake to quote a statement that the President of the United States made in private conversation in his own office with representatives of the American Medical Association.

"2. Because it appears to be altogether probable that the matters referred to in your letter of May 22 will be before the House of Delegates of the American Medical Associa-

tion at its Annual Session to be held within a few weeks."

I submit this quotation from Dr. West's letter without comment. Though I am inhibited from telling you what the A. M. A.'s understanding of President Roosevelt's position was with respect to State control of Medicine at the beginning of his administration, I *am* able to state that the A. M. A. *does not know* what the President's attitude is regarding it at the present time.

With no wish to appear dogmatic, nevertheless I shall state, without circumlocution, my belief that the American Medical Association has permitted the most dangerous and vicious menace ever faced by Medicine to develop to a stage where a national crisis impends, with no policy to circumvent it, no plan to meet it, no program to control it if and when it arrives.

At the present moment it looks very much as if California and Michigan will embrace compulsory health insurance. This only adds to the confusion. This is not a *state* problem, it is a *national* problem and can be met only by *concerted national* action.

In my judgment, the A. M. A. must immediately assume, if it is not already too late, the leadership of *all* Organized Medicine; there can be no State lines in this proposition. I have already, in my letter to the Secretary of the A. M. A., indicated my own thought as to the procedure to be followed.

It would be futile for any one individual alone to attempt to work out a national program. Variations in conditions of practice in the several sections of the country, admittedly make the task of formulating a national program difficult; but, as I said in my letter of last month to Dr. West, I believe with the talent available in the ranks of organized medicine, it would be possible to enlist the services of a representative group who *could* develop a national broad-gauge program adaptable to the diverse needs and conditions of medical practice in the various parts of the country.

The recommendations of the "Minority" of the Committee on the Costs of Medical Care, approved and adopted by the American Medical Association, might well serve as a sound

base for the construction of a national program.

The strictures leveled at the American Medical Association for its failure to assume its obvious responsibility to lead Medicine at this critical period, must be shared by this and every other State Society, unless it shall exhaust all means within its power to bring about such a result.

I offer two recommendations for consideration by the House of Delegates:

1. That this Society continue a policy of progressive and constructive effort *to improve the status of the doctor*.

2. That, if the proposals, advanced in this address, to meet the present menace of State control of Medicine by a national plan and program, appeal to this Society as logical and sound, it instruct the delegates from this Society to the American Medical Association to present to the House of Delegates of the A. M. A. at its meeting June 11th, 1934, resolutions, incorporating the concepts herein set forth to accomplish this purpose.

LOCAL APPRECIATIONS

Either by word of mouth or by letter I have endeavored to express to the officers and members of committees of the Society my deep gratitude for their loyalty and their friendly, willing and intelligent coöperation. In thanking the Presidents of the County Societies, I have recognized the fine support of the component units.

Letters have been sent by me to all members of the State Legislature who supported the passage of Senate-136—"the Physicians' Lien Law". I have not acknowledged in this manner the splendid aid given by Governor A. Harry Moore, because I feel very strongly that the outstanding support by the Governor, of measures espoused by this Society and the allied professions this year is deserving of a wider recognition.

Governor Moore signed the Bill supported by the State Pharmaceutical Association for the Registration of Drug Stores; the Bill supported by the Dental Society to curb false advertising; he signed the "Physicians' Lien Law", and the Bill providing for an emergency

appropriation of \$10,000 for the purchase of toxoid and vaccine. Prior to introduction of the latter Bill, Dr. Mahaffey, Director of the State Department of Health, and I went to Governor Moore's office to enlist his support for this emergency appropriation. After listening carefully for five minutes to the explanation of its purpose, his support was gained with the simple statement: "I am in favor of it."

Governor Moore signed the Bill requiring registration of Drug Stores, after a hearing at which considerable opposition was voiced. He signed the Bill curbing false advertising by dentists, despite the severe opposition of the Press of the State. Governor Moore signed the Physician's Lien Law after a hearing, in the face of opposition of the State Bar Association, insurance companies, and large corporations. In signing these measures, he displayed rare courage and discernment. He convincingly showed his sympathy for the medical profession and an understanding of the necessity, in the interests of public welfare, of keeping the standards of the allied professions high. We owe him and tender him our deepest thanks.

Members of the medical profession occupying seats in the Legislature have given splendid support to measures of professional and public health interest. Dr. Barber, of the Senate, and Drs. McKinstry and Hargrave, of the Assembly, deserve our warmest thanks. Dr. Cole of the Senate and Dr. Newcomb of the Assembly, throughout the session, have been of invaluable assistance to me as Chairman of the Welfare Committee and to Dr. Haggerty, Chairman of the Sub-committee on Legislation.

With the set-up adopted by the Board of Trustees in 1932 now in effect, "to make the affairs of the Society revolve around the Presi-

dent", the Executive Secretary becomes the "assistant to the President" and acts under his direction and authority. This is sound organization. The affairs of an organization *must* be directed and coördinated by the head of that organization. It is the *Society's* function to create policy and program; it is the Executive Secretary's duty to assist and aid the President, in the manner requested, in furthering the carrying out of the policy and program established by the Society, its officers and committees.

Dr. LeRoy A. Wilkes, the Executive Secretary, joined the Society October 1st, 1933. He came to us with a splendid background and wide range of executive, administrative and public health experience. He promptly, easily, and smoothly fitted into the work and activities of the Society. He has done a prodigious amount of work, all of a high order. His ever-ready assistance and the fine spirit and attitude evidenced, is deeply appreciated by me. It is to be hoped that the Society may have the good fortune to retain his services for many years and that, as conditions improve, it may be able to show its appreciation of his worth in a more tangible way.

Dr. Frank Overton in the short time he has been with the Society has clearly demonstrated his capacity as an Editor. I wish to record my thanks for his friendly and valued assistance.

Concluding, may I say that, during every moment of my term, I have been deeply conscious of the great honor and the great responsibility of being President of the Medical Society of New Jersey. This Society, with its proud lineage and history, has the right to expect much of him whom it elevates to this position. I trust my service has met with your approval.

PROJECTS AND POLICIES

THE INAUGURAL ADDRESS OF THE INCOMING PRESIDENT

By LANCELOT ELY, M.D., Somerville, N. J.

Delivered before the House of Delegates of the Medical Society of New Jersey, June 7, 1934

The *Journal* of July, 1933, reported an alteration in procedure "Which establishes the new office of President-Elect and reduces the number of Vice-Presidents from three to two; in other words, instead of having a President and three Vice-Presidents, as heretofore, the Society has now, and will hereafter have, a President, a President-Elect, a First Vice-President, and a Second Vice-President; and annually, from now on, the President-Elect of one year's holding will automatically become President without further process of nomination and election. This amendment was adopted." And, accordingly, I am appearing before you as the first President-Elect of the State Medical Society of New Jersey.

I believe it was Dr. Sommer, in his preliminary remarks to his Presidential address, who said that it seemed strange for a President to outline his policies and recommendations at the end of his term. The office of President-Elect has made it possible that these policies and recommendations be proposed to you in an inaugural address, may we call it, and you may thereby become acquainted with plans for each year's new work of progress in work already started by the retiring President.

When Dr. Quigley became President, he called together the officers of the Society to formulate plans for work which he hoped to promote and carry on during his administration and which we agreed to continue during the immediately succeeding administrations. You have kept in touch with the work of the Board of Trustees, the Welfare Committee and other committees, and know the progress which has been made. Reports of all committees appeared in the May Journal.

You who have not regularly and thoroughly read your Journals, may I urge you to do so. It is the one way to keep in touch with the activities of the Society, first to realize that all

projects undertaken are for the benefit of each individual member; and second to appreciate the amount of time, energy and careful deliberation which so many fellow members



LANCELOT ELY, M.D.

*Inaugurated President of The Medical Society
of New Jersey, June 7, 1934*

are giving to state work. If you are not on the direct firing-line of your State Society, at least be a supporter of its policies.

Public health work must continue from year to year. We should try to have redirected to the physician's office a great part of what has been insidiously slipping into the free care made available to the public through lay organizations, school and hospital clinics.

There should be sought a better coöperation between the triangle of the physician, the patient, and the Workman's Compensation Board.

Too much time is lost in duplication of effort and delay in settlement.

EMERGENCY RELIEF ADMINISTRATION

The Emergency Relief Administration will be continuing, providing medical aid to indigents. The administration is still in the experimental stage. Gradually it will work into a more perfect plan than the present emergency has given time for. A method should be found to spread the sum allotted by the State more evenly throughout the counties, and to cover the entire year. We are not sufficiently acquainted with the plan to use it justly. Physicians should be considerate in their individual claims on the inadequate amount which can be apportioned to this work.

UNIFORM MEDICAL PRACTICE ACT

A *uniform medical practice act* meets the approval of many of our members, and presents many angles to consider as to its form. The pre-medical education of every person attempting to heal the ills of the body should be uniform, no matter what his cult or branch of healing. Such an act must take form in no way weakening to our present position. The old school medical doctor was always reluctant to force himself into the attention of the public. Before he could realize his peril, other practitioners received recognition and favors superior to any granted to the medical profession. Their influence is more pervading and their efforts more persistent than those which we have put forth. Therefore, we must learn to stand together and force a uniform requirement for all practitioners. We must convince our legislators that our aims are not selfish or financial, but are for the protection of the uninformed sick public. Our Society should stand firmly against granting further privilege to any one group of practitioners.

The Welfare Committee is vigilant in its supervision of medical legislation within the state. It is not the policy of our Society to advance new legislation, but we must be ready to meet changing conditions for our own economic welfare.

AUTOMOBILE ACCIDENTS

The ever-increasing motor traffic with its casualties along our highways presents problems only partly cared for by existing legislation. Statistics compiled for 1932-1933, a two-year period, record 2365 deaths and 59,404 injuries within the State of New Jersey alone. It is fair to assume that all of these 62,000 persons received medical attention. Our hospitals are filled and the hospital staffs overburdened with victims of motor vehicle accidents. We have all experienced, furthermore, that much of it is without financial remuneration. Hospital indebtedness mounts because of unpaid treatments. Dr. John J. Morehead, of New York City, writes in the American Medical Association Journal for April, 1931: "The automobile era has changed the sphere of many community hospitals and made them service stations for the care of the injured. In many places the added financial burden of this influx of injured strangers has almost wrecked the institution because the injured persons expect free service for themselves although they pay for a like service to their machines. A portion from the road tax or gasoline tax might be assigned to apply to the upkeep of the hospitals and provide a suitable fee for the professional staff."

DOCTORS' LIEN LAW

The Doctors' Lien Law, which has been signed during Dr. Quigley's administration, will give the means of defense against non-payment of claims. Promptly a schedule of fees should be drawn up which each County Society should file with the County Clerk. Now that this is a law, a schedule should be arranged immediately, in coöperation with the State Society Committee which has already been appointed (page 351).

It is not only our services which we give for the relief of human suffering. In many cases, months and even years after the accident, we are required to attend court hearings, the hospital to furnish records, the radiologist to interpret x-ray plates, and the doctor to give testimony. All too often this service of the hospital, x-ray specialist, and surgeon is also

without financial appreciation. This is especially so if the trial ends in non-suit or no cause for action. Often the cases are tried in a distant town, meaning the loss of several hours of time to the physician and great inconvenience in his routine work. I have had the experience of being called to attend court three times in one week, each time at a different court, in a different section of the state, and in all these cases, there was no financial return. Or, we are requested to report on a given day, we rearrange our work to respond, and await a call for a definite hour. Nothing is heard from the attorney on the given day, nor the next, and casually we hear that the case has been settled out of court or postponed. I am sure my own experiences have been duplicated by many of you. Closer co-operation between the attorney and physician, and common courtesy could eliminate many of the existing misunderstandings. I should like to see such an agreement devised during this next year.

FREE CLINICS

Free clinics and ward treatments at hospitals require the free services of physicians and surgeons. The number of such cases has rapidly increased during the last two or three years. Dr. S. S. Goldwater, Commissioner of Hospitals of New York City, in the American Medical Bulletin for January, 1933, says: "Although the annual reports of hospitals are valuable sources of information concerning certain hospital activities, they are strangely silent in relation to one of the major aspects of hospital service, namely, the gratuitous service of the physician who is bound up with ordinary hospital practice. Those who have been identified with hospital administration and have shared in the preparation of hospital reports know that the omission is due to thoughtlessness and not to any desire to conceal a vital part of medico-social economics. Nevertheless, it is high time the hospital should mend its ways."

Except for the Board of Directors of hospitals, all hospital workers are paid for their time and services. Only the doctor is expected to be altruistic, and although we would be reluctant, as medical practitioners, to barter our

services in the care of the needy, yet with such a large proportion of the public being cared for at clinics and in hospital wards, where is the doctor to get compensation sufficient to maintain his living unless some method of payment is arranged for hospital work?

Practically all hospitals have been started by some physician or group of physicians requiring a place to supply their patients with more convenient and better care than they had been receiving. As the project has grown, it has developed beyond the economic possibilities of the physician to maintain. It still remains his so-called workshop, even though its management has gone so completely out of his hands. Because his services are vital to its maintenance, every hospital board should appreciate the necessity of keeping itself in a close relationship with the hospital staff, with consultation on important hospital questions. It should be a mutually helpful institution instead of, as it is considered in some communities, the doctor's greatest competitor.

WOMAN'S AUXILIARY

The Woman's Auxiliary is year by year growing into a stronger organization which the Medical Society can make a valuable asset in welfare work. The ladies are awaiting our requests and I know they will respond wholeheartedly. Certain work in each County Society may be referred to the County Auxiliary.

SPEAKERS' BUREAU

During the past year many requests have been received for a speaker on medical subjects which could not be filled. I trust that in the near future, with the help of the Woman's Auxiliary, we may have organized a *Speakers' Bureau*, the speakers to be drawn from among our own members or the members of the Woman's Auxiliary.

In connection with the Speakers' Bureau may be a supply of literature and pamphlets on public health education or prepared articles on medical subjects for loan to lay clubs and organizations. A means to counteract the extravagant claims of radio advertisements might be an occasional article of medical informa-

tion sent out from the Speakers' Bureau after endorsement and approval of the State Medical Society. These articles would appear in local newspapers throughout the state under the name of each County Society, and would be intended to convey information on health subjects or interpretation of medical legislation for the lay public. Short articles might also be prepared for broadcasting on occa-

sional or regular hours under the auspices of the State Medical Society.

CO-OPERATION

We seek close coöperation with the State Board of Health, the Child Welfare Board, the Board of Medical Examiners, and the Department of Institutions and Agencies.

SURGICAL MASTOIDITIS IN INFANTS

By WILLIAM J. GREENFIELD, M.D., East Orange, N. J.

Read before the Section on Pediatrics at the Annual Meeting of the State Medical Society at Atlantic City, June 7, 1933

There is a disease entity peculiar to infants characterized by gradual loss of weight, persistent fever, intermittent diarrhea and vomiting associated with otitis media. The onset may be marked by no acute ear disturbances such as pain or mastoid swelling. As a matter of fact, the drum may show no bulging of the membrane and may be only moderately reddened and injected. There may be no drooping of the auditory canal wall to suggest a definite surgical mastoid as typically described in the text books.

The infant shows a gradual decline with a characteristic watery stools associated with a gradual dehydration.

The relation of gastro-enteric symptoms to acute otitis media is well known to pediatricians.

An acute attack of diarrhea and vomiting calls for an examination of the throat and ears as well as the intestinal tract. Where the examination is made in all new cases of gastro-enteritis, as is done in the best clinics, a marked involvement of the throat or ears is disclosed in a large proportion of the cases.

Whenever children are brought to the clinics for gastro-entero symptoms, the associated throat and ear symptoms may exist in three stages or areas, according to the extent of the involvement. First, the throat alone; second, the middle ear cavity; and third, mastoid cells. All degrees of chronicity of conditions may exist in both the abdominal organs, the throat and the ear. If both systems are involved, the

treatment of each is necessary in order to cure the other, and this treatment is almost the same as if it existed alone.

The result of a chronic condition in the intestines is usually marasmus, and in the ear it is often mastoiditis. However, these two conditions may exist together.

The present paper will deal with the chronic condition usually called marasmus, which is dependent upon mastoiditis. It is a clinical report of eighteen cases illustrating the types and combinations of mastoiditis and marasmus. These cases are grouped according to the following outline:

GROUPING OF THESE CASES

- I. Marasmus without ear infection.
- II. Marasmus with ear infection.
 1. Secondary to ear infection.
 2. Ear infection secondary to marasmus.
- III. Acute suppurative otitis media without obvious (clinical) mastoiditis.
 1. Which may lead to marasmus if not stopped by operation.
 2. With complications, such as facial paralysis.
- IV. Acute suppurative otitis media with clinical mastoiditis.
- V. Subacute suppurative otitis media without surgical mastoiditis with general condition normal.

Mastoid antrotomy to prevent chronicity with its accompanying deafness.

GROUP I. MARASMUS WITHOUT EAR INFECTION

Case 1

Robert A. Age—one month. Admitted December 5, 1932.

After an illness of four days, beginning with vomiting and continuing with diarrhea, loss of weight and dehydration, the temperature rose to 104.8° F. and death occurred on the third day in the hospital. Autopsy showed no involvement of either mastoid.

Comment: This was apparently a straight marasmus case with no evidence of any focus of acute infection present, especially in the mastoid, as proven by the autopsy. The patient was too sick to be influenced by a change in the diet formula. The patient was moribund on admittance.

Case 2

John A. Age—five months. Admitted June 17, 1930.

After fever and crying spells lasting a week, there was a profuse yellow discharge from the right ear, associated with swelling over the right mastoid. The left ear-drum appeared normal. A mastoid operation was done and there was a gradual loss of weight of 20 oz. during the post-operative period of 18 days. On July 18, three weeks after his discharge from the hospital, the patient developed an acute gastro-enteritis with diarrhea, which persisted for two weeks. Recovery followed in two weeks more. This second condition promptly subsided under proper diet because the mastoid infection had been eliminated.

Comment: This is a case of marasmus secondary to a dietary disturbance. The previous infectious disturbances may have made the infant more susceptible to a nutritional imbalance.

GROUP II. MARASMUS WITH EAR INFECTION —MALNUTRITION SECONDARY TO EAR INFECTION

Case 3

Frank D. Age—three months. Admitted March 4, 1932, in normal condition.

The patient immediately developed diarrhea and became dehydrated. There was a three-pound loss in weight in 23 days when a bilateral mastoid operation was performed, followed by immediate recovery.

Comment: Surgery here was a life-saving measure. Infection here certainly was the pre-

dominating factor with a definite reversal in its general condition when the infection was removed.

Case 4

John T. Age—three months. Admitted April 11, 1930, with swelling over left mastoid, beginning a week before admittance.

Following the mastoid operation, the patient developed diarrhea, loss of appetite, associated with loss of weight, secondary to retention of pus in the mastoid and impetigo of the scalp. On proper care of this complication, the patient regained appetite and weight.

Comment: This case suggests a marasmic state secondary to continued infection. The original infection with delay in its elimination may have made it liable or susceptible to a nutritional imbalance. The accumulation of infective material in the body caused an imbalance with a resultant marasmic state. The drainage of the infected areas caused prompt recovery.

Case 5

Gertrude M. Age—five months. Admitted February 26, 1931, with vomiting, cough and failure to gain weight. Right ear drained pus, stools were loose and watery and patient was dehydrated. Temperature was 101°. Condition grew gradually worse and patient died four weeks after admission. No examination of left ear was made.

Comment: Analysis of this record shows without doubt that the child's malnutrition syndrome could be due to the mastoid and middle-ear infection. The left middle-ear and mastoid were infected and the cavities were entirely closed without any drainage except through the eustachian tubes. I cannot help but feel that in the light of other cases, incision of the left ear drum and probably a bilateral antrotomy may have changed the fatal outcome.

Case 6

Viola S. Age—five weeks. Admitted September 24, 1932, gasping for breath.

Patient was badly under-nourished and dehydrated. The ears were normal. The temperature was sub-normal. The child died three days after admittance. Autopsy showed both mastoid antra filled with pure pus.

Comment: Infant was admitted in too bad a condition to be helped. This case is presented

to show the presence of pneumococcus infection in both mastoids of an infant who died without operation. This infection must have been present for some time and gradually produced the extreme athrepsia and death. The report of a negative ear examination means very little as you see. Unless ear examinations are made by one experienced in these cases, the opportunity for help may be overlooked.

Case 7

Robert P. Age—ten months. Admitted September 2, 1932, with swelling on the right side of his neck, due to cervical adenitis.

The patient had diarrhea, became dehydrated with loss of weight. Patient refused food and continued to vomit. Leukocytes increased to 21,000. Temperature became septic in a range between 101 and 104°. Bilateral mastoid operation was performed under ether anesthesia. Patient died on operating table.

Comment: In this case, the operation was performed too late. There was too much shock for the patient to survive.

Case 8

Walter D. Age—nine months. Admitted December 26, 1932, with cough, restlessness and poor appetite.

Patient observed on two previous occasions at the Hackensack Hospital for pyloric spasm and marasmus. Temperature was 102.4°. Chest examination revealed broncho-pneumonia. The ear drums were reddened with land marks absent. There was marked nasal discharge. Patient became dehydrated and lost weight. Bilateral mastoid operation was performed under local anesthesia. Temperature became normal in five days. Wheezing persisted after operation, however, due to an acute edematous laryngitis. Six days after operation, temperature became septic up to 105° and patient died six days later of sepsis.

Comment: This patient had a tendency towards malnutrition as evidenced by a nutritional disturbance on a previous hospital visit, recovering on a correct hospital diet. The second visit was characterized by the inception of its secondary nasal and aural infection from which it temporarily recovered for two weeks.

Two weeks after the second dismissal, patient was readmitted, very ill, with typical signs of advancing anhydremia, loss of weight and appetite. Myringotomy failed to stop the disease, so a double mastoid operation was

done. This caused a temporary improvement but failed to prevent the fatal outcome. There was still sufficient infection in the nose and larynx to prevent recovery. This case demonstrates the importance of infection either as a contributing cause or as an actual cause.

GROUP III. ACUTE SUPPURATIVE OTITIS MEDIA WITHOUT OBVIOUS (CLINICAL) MASTOIDITIS

Division 1. Which may lead to marasmus if not stopped by operation.

Case 9

Anna G. Age—thirteen months. Admitted February 28, 1931, with loss of weight, poor appetite and cough. Observed in Bellevue Hospital one month previous for discharge in the ears. Immediately after removal from Bellevue Hospital, patient developed severe cough, became restless and ran high temperature. Patient became dehydrated and had severe diarrhea. Six days after admittance a bilateral mastoid operation was performed under ether anesthesia. Both mastoid antra were filled with pus. Patient died three days after operation from broncho-pneumonia.

Comment: Experience now tells us that the severity of the clinical picture was not immediately realized. Neither was the importance of the aural infection appreciated until it was too late. There is no doubt that this child's clinical syndrome of malnutrition was due to the infection the child received one month before admittance to the hospital. The aural discharge may have lessened when she was discharged previously from the hospital, but the general condition of the child had not improved and for that reason should have been kept under close observation.

Case 10

Howard S. Age—four years. Admitted March 13, 1933, with fever and discharge from the right ear.

After four weeks of observation because of persistent temperature, high leukocytes count of 26,000 and gradual general debility, double mastoid operation was performed under ether. After operation, temperature persisted associated with headache. Thirteen days after the original operation the left mastoid was reopened. Patient immediately recovered.

Comment: This case is presented to show the marked ill-effect a few retained cells in a

partially operated mastoid may have on a young patient. The patient looked ill, had no appetite and did not feel well. This was all corrected by the second mastoid operation.

Case 11

Flora J. Age—two years. Admitted March 29, 1933, with convulsions, associated with discharging nose.

Temperature was septic from 100° to 106°. Both eardrums were reddened and full and were incised with immediate complete relief.

Comment: Convulsions are not uncommon in infants secondary to acute otitis media. A good pediatrician once diagnosed a case "tubercular meningitis" and stated he was in doubt about the ear drums which he had examined. After considerable cerumen was removed from the canals, the drums presented a loss of luster with absent landmarks. A bilateral myringotomy was done. This so-called "tubercular meningitis" immediately disappeared. It apparently was a meningismus, secondary to the ear infection.

Case 12

Eleanor M. Age—nine months. Admitted with discharging ear, anorexia, cough and fever.

Patient was restless, wheezed and looked very ill. There was evidence of rickets. Moist râles were heard over the base of both lungs posteriorly. Bilateral myringotomy gave no relief in four days so a double mastoid was performed under local anesthesia with immediate relief of temperature and gain in weight.

Comment: This case illustrates the fact that removal of the infective foci in the mastoids immediately relieves these infants and that this method is without shock or apparent risk.

Case 13

William K. Age—fifteen months. Admitted March 11, 1932, with a history of discharging left ear for three weeks and convulsions.

A low grade temperature persisted for a week when both eardrums were incised. Patient continued to lose weight and became dehydrated. Bilateral mastoidectomy was performed under ether anesthesia, one month after admittance, followed by immediate gain in weight, normal appetite and normal temperature.

Comment: This case is similar to two preceding cases. Ether was used because the child's general condition was sufficiently good so as not to be disturbed or shocked by the ether anesthesia.

DIVISION 2. WITH COMPLICATIONS—SUCH AS FACIAL PARALYSIS

Case 14

Joan W. (Colored). Age—one year. Admitted January 2, 1933, with left facial paralysis, associated with upper left cervical swelling which was incised and drained one week after admittance.

The left eardrum was reddened with absent landmarks. The x-ray showed a slight degree of bone absorption in the region of the left mastoid antrum. A left myringotomy produced discharge only after three days with no change in the paralysis. A left mastoid operation revealed a large developed mastoid with deep lying cells filled with granulations around the antral portion of the facial nerve. Facial paralysis recovered in two weeks. The child gained rapidly in weight.

Comment: There was nothing in the ear to indicate a severe mastoid infection, except a bare trace of discharge three days after opening the drum. The myringotomy was only performed because the ear drum was not quite normal. At first the ear condition did not seem sufficient to account for the facial paralysis. The temperature was normal and pulse 110 three days preceding the mastoid operation. The operation was performed as an exploratory procedure substantiated by the x-ray.

GROUP IV. ACUTE SUPPURATIVE OTITIS MEDIA WITH CLINICAL MASTOIDITIS

Case 15

Martha C. Age—eight months. Admitted December 27, 1933, with cough, rhinorrhea, listlessness and fever. Patient had been ill for two weeks with bilateral otorrhea. After three days in the hospital, while being treated for broncho-pneumonia, the temperature became septic, pulse unpalpable and respirations rose to 80. The chest became essentially negative and because of the severity of the patient's ailment, after eight days, a bilateral mastoid operation was performed under local anesthesia. Much pus was found on both sides.

Comment: A straight case of acute mastoiditis with typical clinical findings. The infant underwent the operation without shock and without any general disturbance. Immediate recovery followed the operation.

Case 16

Alfred N. Age 3½ months. Admitted on December 15, 1932, with discharging right ear and swelling over both mastoids and pain in the left ear. The left drum was moderately reddened. A bilateral mastoid operation was performed under local anesthesia with immediate recovery.

Comment: The younger the infants, the more we incline to local anesthesia.

GROUP V. SUBACUTE SUPPURATIVE OTITIS MEDIA WITHOUT CLINICAL MASTOIDITIS WITH GENERAL CONDITION NORMAL

Mastoid Antrotomy to Prevent Chronicity with Its Accompanying Deafness

Case 17

Charles G. Age—seven months. Patient admitted to the hospital three months previously because of inanition, malnutrition, loss of weight and lobar pneumonia.

There was a spontaneous discharge from the ears a few days after admittance with immediate recovery. Both ears persisted in discharging for three months so a bilateral mastoid operation was performed under local anesthesia to prevent chronicity. Pure pus was found in both antra. The aural discharge ceased and patient continued to gain after operation.

Comment: This patient recovered from its malnutrition state in spite of its ear infection. Drainage through the ear drum gave sufficient relief. Adenoidectomy had no effect on the aural discharge. Culture from both mastoids showed streptococci.

Case 18

Caroline L. Age—ten months. Admitted December 2, 1932, with bilateral subacute otitis media, having persisted for six weeks.

A bilateral mastoid operation was performed under local anesthesia, followed by immediate gain in weight and cessation of aural discharge.

Comment: The operation was also performed to prevent chronicity and its attendant deafness as well as to relieve the inflammatory condition.

ANALYSIS OF CASES

The following is a brief summary of the eighteen cases studied above:

Of the two cases without otitic infection with marasmus, one died and one lived. The one that died was admitted moribund. The other case recovered by correct feeding.

Of the six cases with marasmus with ear infection, two recovered and four died. Two died without the benefit of an operation and the other two died following mastoid opera-

tion. Operation was performed too late in the third death, when the patient was in extremis. In the fourth case, death was due to persistent complicating laryngeal sepsis which would not be relieved in spite of adequate treatment although the patient withstood the local mastoid operation without shock.

Of the five cases with primary otitis followed by secondary marasmus, four recovered and one died. The only death in this group was due to operation performed too late and under ether anesthesia. The patient died a typical marasmic death complicated by bronchopneumonia.

The infant with facial paralysis due to local mastoid pathology made a complete recovery.

In Group IV, two infants, 3½ and 8 months of age, were operated under local anesthesia and made a perfect recovery. Both had a tendency to become marasmic.

In group V, both patients 7 and 10 months of age, were in perfect health except for running ears. One infant had his adenoids removed. Both cases after operation had dry ears and healthy healed mastoid scars.

CONCLUSIONS

1. Infants having otitic infection associated with marasmus which cannot be controlled should have the benefit of mastoid surgery.

2. The mastoid operation in marasmic cases should always be bilateral.

3. The mastoid operation in marasmic cases should always be performed under local anesthesia if the general condition is not good or if the patient is very young.

4. Subacute otorrhea justifies its removal by operation after a certain period has elapsed if certain conditions have been fulfilled.

5. Let me make a special plea for the urgency of special ear examinations made by one versed in surgery of the ear who has had experience in clinical observations in infants with ear disturbances. This is a special field of its own where the evaluation of certain special symptoms and signs may decide the life or death of an infant. The opportune time for surgical interference is decisive and must be and can be decided on the definite concrete evidence present.

SUPRAPUBIC PROSTATECTOMY

By THOMAS C. STELLWAGEN, M.D., Philadelphia, Pa.

Read before the General Session of the Medical Society of New Jersey, at the Annual Meeting,
June 7, 1933

Operations for the relief of symptoms caused by enlarged prostates are among the earliest forms of surgery. The perineal route of entering the bladder was usually preferred on account of the length of time required for the suprapubic operation. However, with the introduction of asepsis and the development of modern methods of operating, the suprapubic method came into general use, though with much controversy and contention over credits for discovery and priority.

Sir Henry Thompson taught that 34 per cent of men over 60 years of age have some prostatic hypertrophy. This statement, we think, is still tenable. Probably one-half of these 34 in 100 have symptoms of prostatism, and one-half of the remainder, practically speaking, have trouble from vesical outlet interference that often necessitates relief by some form of operative removal.

If we accept the above statement as true, it becomes the duty of the doctor to be alert to the possibilities and early recognition of prostatic disease. It is only by a well-ordered plan of examination that the family physician, who is the out-post picket, will be upon his guard to recognize the offending prostatic obstructions, infections, and malignancies. In view of this fact, it should be a routine to make a rectal examination upon the majority of male patients past forty years of age. Some will contend that a rectal examination by digital touch is unnecessary, offensive and uncalled for. Grant that in certain instances it is. It is also an unassailable fact that the physician who bears this necessity in mind will not suffer the ignominy of having someone take him to account for a lack of study of the patient. Again, in many instances, latent prostatic infections will be recognized; and if you accept the modern conceptions of focal infections as provocative of many ailments, the necessity for ruling the prostate out of the picture becomes more potent.

When the victim of prostatism presents him-

self for study, the surgeon should proceed carefully, and not be over-enthusiastic to hurtle the subject into numerous examinations of the bladder by cystoscopic study or other complicated instrumental procedures. A careful examination of the internal organs should be made first, particularly of the heart, kidneys, and lungs. The vaso-motor problems must be considered, and one should feel his way gradually before shocking the subject by a cold-blooded statement of operative necessity. It is more humane to approach this problem by degrees. If there is a doubt as to his fitness to withstand the dangers of an operation, the surgeon will do well to call in a medical consultant who is experienced in the evaluation of the problems presented. It has been my custom to so do. One cannot be conversant with all of medicine, and the man who knows it all is an unsafe doctor. I might say that the admonition to call an internist who knows the wiles of prostatism is a very important consideration. There have been times when the medical man's opinion and our own have differed as to the ultimate ability of the patient to withstand operative shock. We must never lose sight of the recuperative powers of Mother Nature to come to our rescue in reconstruction of the patient, provided she is given a fair chance.

THE EXAMINATION

We will attempt to outline the various methods of studying the prostate gland, and to allot to them their value and consideration in determining the proper treatment. This study will be made along six lines.

- (1) A thorough history taking.
- (2) A rectal examination.
- (3) The bladder, capacity retention, etc.
- (4) A cystoscopic examination.
- (5) Laboratory tests, elimination, blood tests, etc.
- (6) The medical consultation.

FIRST EXAMINATION, THE HISTORY

A complete history of the case is necessary not only for diagnosis, but also for prognosis, and for the determination of the method of proper treatment.

SECOND EXAMINATION, THE DIGITAL TOUCH PER RECTUM

The patient is best examined upon an operating table upon his hands and knees. The sphincteric area and entrance to the rectum are carefully looked over for pathology. A fissure, a polyp, an inflamed hemorrhoid and spasm must be considered, and the gentle insertion of the finger is essential to proper relaxation. Without relaxation, much may be left to the imagination. Local anesthesia may be a valuable adjuvant. The examining finger can detect fecal impactions and the extent of the prostatic involvement, whether it be in the lobe of Home or isthmus or the lateral. Fibroses, hard and soft areas, can be sought out and their limitations determined. The vesicles may at times be felt and a previous servitude to venereal disease at least surmised. The general fixation of the vesical neck is also important. Where such is the case it is well to be guarded in your statement to the patient and family, since malignancy is far more common than generally believed. Statistical analyses place it between four and twenty-five per cent. The trained finger can usually determine it at this time. The diagnosis of it will be fortified by a history of pain radiating into the sacro-iliac region, down the posterior aspect of the thighs, and, strange to say, at times into the ball of the foot. These cases are often mistakenly treated as sciatics or sacro-iliacs. Again when shows of haematuria, loss of weight, and cachexia are linked with the findings, it becomes a more ominous syndrome.

It must not be forgotten that the enlargement may be an intra-vesicular projection, or a very small and indefinable hypertrophy in the median line of the subserous glands. Dr. Randall by his brilliant studies has very graphically proved the potentiality of these small outgrowths when so situated as to interfere with bladder function as much as the massive lobar hypertrophies. When a patient's history

has been definitely one of beginning or well established prostatism, don't say "no pathology" simply because nothing striking demonstrative can be felt. Again at this time, never lose sight of the possibility of spinal injury by trauma or syphilis. After rectal examination has been completed, the penis is milked and any secretion obtained should be examined both wet and stained. At times cultures may be necessary for a vaccine.

THIRD EXAMINATION, THE BLADDER

When possible, it is always proper to determine the carrying capacity of the bladder and the amount of residual urine. This is better done at another visit since the disturbance caused by the rectal examination may induce false findings through the element of spasm and nervous imbalance. The information gained by the rectal examination can be applied in this study particularly as to the selection of the type of catheter used to determine the residual urine and the carrying capacity. It is rarely wrong to attempt catheterization by the soft rubber catheter. If it does not pass, then have recourse to one of the several types that your studies of the enlargement will dictate.

If the median lobe is markedly involved in the hypertrophic process, the B. Coude will probably pass, since its construction enables it to override the dam breast produced by the enlargement.

The final conclusions as to residual urine should be accepted only after several tests. It is understood that this presentation is not considering the problem of retention. There, of course, we believe in gradual decompression of the bladder.

FOURTH EXAMINATION, CYSTOSCOPIC STUDY

This phase of the problem is eminently important when it can be done without too much trauma and shock. We have heard urologists state that all prostatic cases should be cystoscoped. This statement, if accepted without reservation and broad experience, will lead one into serious difficulties. Cystoscopic examination may be interdicted. It should, in most instances, be deferred until the case is sufficiently detoxicated so that the examination

does not become the straw that breaks the camel's back by inducing uraemia. Therefore, it is mandatory to be ever considerate of the cold facts. One naturally asks the question: "Do you do prostates without cystoscopic study?" Our answer is that we have, and will so continue when the case warrants such judgment. The next question as a sequel is: "What procedure do you resort to in lieu of cystoscopic examination?" The answer is: "A thorough x-ray study including cystographic pictures, and at the same time a search for possible bony sclerotic changes associated with malignancy." Just here we should add that all prostate cases are subjected to careful x-ray studies by the above rulings irrespective of the cystoscopic findings. There is no cystoscopist who is infallible. Diverticula can be missed and so can encysted stones; therefore, the dual examination we think is advisable and is our routine when possible. In those cases where extreme intolerance is the picture, the judicious use of belladonna may be good judgment. This also is resorted to in pyelographic studies where spasticity of the structure inhibits good films. If intravenous urography has been done, it will often suffice for the bladder pictures.

One problem that I hope will be brought out in the discussion is the preparation of the patient for x-ray study. Gas has been a far too common deterrent of good radiographic pictures and I confess it has been a consuming problem with us in Jefferson. We have run the gamut of methods of preparation, therefore, any suggestions will be happily received and recorded.

FIFTH EXAMINATION, ELIMINATION TESTS

In this series of preliminary studies the outstanding ones are the phenolsulphonaphthalein elimination and the indigo carmine colorimetric test of kidney efficiency. If the case was cystoscoped, the indigo carmine test was done at that time, and the phenolsulphonaphthalein as a check-up. In reference to dye tests in functional capacity of the kidneys, one must not be given to accepting them with the same confidence that some do. They may differ greatly in the same case under apparently the same conditions. I don't condemn them but you

must remember that they constitute but a cog or two in the wheel of study.

The ordinary and differential blood examinations are made; from them we may learn much of value. Clotting and bleeding time are very important and routinely done. The chemistry of the blood is, we believe, the most important preliminary test. The question as to which the palm should be awarded—it or the urea clearance test—is an open subject with me. The non-protein nitrogen estimation has been a guiding star with us and still is. Blood sugar is also a very necessary study. Creatinine we do not do as a routine except where the findings warrant its determination. I have always felt that it was the index of the final shot that put the finish to the patient. In very toxic cases it is a useful index as to the range of the toxemia. High creatinines are always an admonishing signal that must be observed. A railroad would not select an engineer who was color blind; and the same token is applicable to a cock-sure surgeon who is aesthetic to blood chemistry and functional dye tests.

The routine urinary findings are also of great importance and should be carefully considered along with output. The urologist who is an expert in the therapeutics of water is fortunate. The handling of it is an art and well furnished is the man who understands its use. Of all the remedies at our command, we place it first when leavened with judgment. The patient who handles water successfully is a far better surgical risk to embark upon the sea of prostatic trouble than he who becomes water logged. No seafaring man would venture abroad in a water-logged hulk, hence, it is always well to understand the tolerance and capacity of the kidneys to water. When we say water in a sense we include those foods and stimulants such as sodium chloride and glucose that are carried to the system by it as a medium.

SIXTH EXAMINATION, THE MEDICAL CONSULTATION

The medical consultant is, we know, one of the most important considerations. We rarely attack the prostate without his opinion as to the fitness of the patient to make the voyage.

Digitalis here bears a similar relationship to the internist as does water to the urologist. Its use is also a divine art that some men never learn. These problems I have always relegated to my colleague, Dr. Griffith, to whom I wish at this time to acknowledge my indebtedness.

Where a tenable doubt exists as to the status of the cardio-vascular system, cardiography is done. Blood pressure is most important, and routine daily estimations are to be charted.

PROSTATECTOMY

The suprapubic approach to the prostate gland has been defined in stages, namely, one, two, and three. These distinctions are important and we feel should be considered in this paper. First, we hark back to the earlier days when the operation was performed in one stage; this was the formative period. Surgeons learned that much of the mortality associated with the operation resulted from putting an added burden of operative shock upon kidneys that were over-loaded because of obstruction and resultant infection. It was finally determined that a period of drainage would often overcome the lameness of the kidneys, and in consequence the two-stage operation was favored. It was a great step forward and unquestionably reduced mortality.

The question here arises: "Has the one-stage suprapubic operation been ruled out?" My answer is, "No." It becomes a question of individual judgment of the surgeon as to when the one, two, or the three-stage operation should be done. I have always maintained that, given a mildly infected prostatic case wherein the kidneys are not seriously affected, the one-stage operation is allowable. However, where a doubt exists, the two-stage procedure has been our choice. This decision is arrived at by a careful study of the entire picture of the case. We don't advise it routinely. Our personal mortality rate has not been increased by this ruling.

The next problem that presents itself is what is the necessity for three stages. As I see it, they are as follows: In grossly infected bladders where the infection is of a character that the surgeon believes the patient will suffer

the morbidity and toxemia induced by prolonged infection of the pre- and para-vesical spaces, then the three-stage operation may be the safest. This is true in those cases where the danger of an alkaligenis infection is in the picture. It has been our experience that the morsellation necrosis that accompanies some suprapubic cases will be prevented by the addition of the third stage. In Jefferson, I have had recourse to this method when my judgment so dictated.

Another question is always a potent one. I have seen prostatics die between the periods of the stages in prostatectomies. In lieu of a better explanation, the poor victims lost heart and gave up the fight when they awoke to find they faced another operative ordeal. To me the nervous torture of knowing another anesthesia was necessary, as also an operation was the cause of the loss of the moral fighting force. We think it most important to nurture the desire to live in prostatic cases. The surgeon must use persuasion, diplomacy and strong-arm methods to keep active the fighting spirit.

It is at this time that alcohol carefully administered may do much.

The question of vasectomy is an important one, and today where gross infection is the situation, a preliminary vasectomy is done. This has eliminated epididymitis—a distressing complication. My ruling used to be that when a prostatic case ran a fever post-operatively after a week, and that came on rather suddenly, look for the origin in three places: the lungs; the bladder, because of poor drainage; and always the vesicles and epididymis.

The selection of an anesthetic is a very important question. There is no safe anesthetic. We do not brook careless, haphazard or routine selection of the anesthetic. Ether was in the past given, and we still use it. Nitrous oxide and ether sequence is also good. Nitrous oxide is excellent when administered by a skilled anesthetist. Spinal anesthesia is the ideal method when it is warranted. Caudal anesthesia is also very satisfactory, when it works. I have never been a party to complicated combinations of anesthetics—they are comparable to intricate mechanical devices that

are too temperamental to be reliable. I have often thought that some surgeons are so consumed with the idea of being the first or among the pioneers to adopt some new method of anesthesia that they are dangerous. We all admire the fellow with the spark of brilliance, but we of the common run of the mill must never forget that our commodity is human life. Therefore, think, weigh, listen, and mentally digest the problem of anesthesia before you operate. It is here that the internist's opinion is of paramount importance.

In dressing for the operation, it has been our custom to put on the regulation surgical gloves. Over the left hand we place, directly over the regulation glove, an extra long version glove that extends well above the elbow. This can be readily removed when the left index finger has completed its work in presenting the prostate in the bladder enucleation. This procedure obviates the necessity of a change of gown and gloves, and also protects the operator's forearm from contamination and danger of infection. It likewise conserves time.

PREPARATION OF THE OPERATIVE FIELD

The scrotum, the penis, the bladder and the urethra have been carefully and thoroughly done. The selected anesthesia is given in a quiet atmosphere, preferably away from the hurry and bustle of preparation. It is not a wise plan to subject the mentally impressionable patient to the sight of the modern surgical operating room. It is a distinct deterrent to poise and nervous relaxation. A catheter is passed and the bladder gently lavaged after anesthesia is complete. The bladder is distended under the eye and feel of the surgeon. We have done many cystotomies without distension, but injury to the peritoneum is more likely to happen when so done. This has occurred to us; we always, when possible, know the carrying capacity and are guided by it in the filling of the bladder. I have seen bladders ruptured upon the operating table by over distension. We don't use a syringe as a routine for filling; the gravity method is preferred.

(Dr. Stellwagen closed his paper with a technical description of the actual operation of suprapubic prostatectomy.—Editorial note.)

ABSORPTION OF DECOMPOSITION PRODUCTS OF SWEAT AS AN ETIOLOGIC FACTOR IN VITILIGO

By WILLIAM O. ROOF, M.D., Atlantic City, N. J.

Read before the General Staff of the Atlantic City Hospital, February 23, 1934

The etiology of vitiligo is one of the enigmas of dermatology. The texts on dermatology present little or nothing new in the various theories as to the cause of this malady. The following are recited as in some way linked up with the etiology, viz: A trophoneurosis and occurring most frequently in neurotic individuals; related to disease of the suprarenals; frequently found to follow febrile diseases; more prevalent in tropical climates, rarer in colder climates. Syphilis, too, has been mentioned as being a causal factor, and recently, Cannon and Karellitz in a highly scientific and valuable contribution, claim it is due to arsenic retention.

One of the older authorities, Morrow, makes bold with the following statement: "It is held by some that the disease is due to a dis-

turbance of innervation, an explanation which tells us nothing and is only a cloak to hide our ignorance; the microscope reveals nothing but absence of pigment." With modern texts presenting only theories as to the etiology and with the mechanism of these theories left to our individual imaginations, I feel that I may with propriety, not merely present a new theory, but at the same time support it with a plausible explanation of the processes involved and show how it dovetails with certain well-known and accepted facts incident to the disease.

The ultimate proof involves an intricate problem in biochemical research and it is my expectation to present, at a later time, certain biochemical findings sufficient to confirm this theory.

SWEAT AS A CAUSE

Simply stated, the theory is as follows: Vitiligo is the result of absorption by the skin of certain decomposition products of sweat which has remained, and undergone chemical change on the skin. This chemical, as yet undetermined, may be ammonia, or ammonia carbonate and carbamate, and when so absorbed, depigments the skin by acting as a bleaching agent on the melanin of the pigment cells. The absorptive power of the skin is so definitely acknowledged and readily proven that it is unnecessary to elaborate on this point here, suf-



Fig. 1. (Case 4.) Showing vitiligo limited to scrotum, one of special sweat sites referred to. Patient sought relief from discomfort caused by excessive sweating of part.

fice to say, it is this function of the skin which contributes to the possibility and plausibility of our theory.

Why is sweat, or its decomposition products, suspected?

During the past summer three female patients consulted me for treatment of beginning vitiligo; also one middle-aged man with vitiligo of three years' duration and limited to his scrotum.

Case No. 1. A woman aged 35 presented herself with vitiligo limited to the axillae, except that from the left axilla there was an extension of the process, about the size of a quarter appearing just below the left scapular border. She first noticed the depigmentation about four months previously

and complained of profuse sweating especially in the axillae and she wore sweat shields to protect her clothing. The vitiligoid patch in right axilla nearly approximated the outline of the shield. Patient stated her tendency to excessive sweating began about a year ago. Her health in other respects was normal. Urine negative. Blood Wassermann negative.

Case No. 2. A light-colored woman aged 28 presented herself with a dime-sized patch of vitiligo in center of her forehead. It was of two months' duration. She complained, also, of excessive sweating, particularly about the face and head and stated that the perspiration had an especially strong, pungent odor; so that her friends persuaded her to seek medical advice both for the sweat condition and the white patch on her forehead. Her general health was good. Blood Wassermann negative.

Case No. 3. A school girl aged 15 presented herself with three pea to dime-sized patches of vitiligo on right side of her face. The condition was of three months' duration. She was much interested in gymnasium work and had been leading a strenuous out-of-door life, much of the time on the beach, exposed to the sun. Her face was profusely bathed in perspiration as I examined her. General health apparently normal. Blood Wassermann negative.

Case No. 4. A professional man aged 42 presented himself for excessive sweating and pruritus of his scrotum; the condition recurred at intervals during the past three years. Examination revealed a piebald appearance of the scrotum, most of the pigment having disappeared. The scrotum was bathed in sweat and irritated from scratching on account of the associated pruritus. To best of his knowledge, the vitiligo had existed for nearly three years. He had previously sought medical advice for the vitiligo and was convinced treatment for this condition was useless, and he was now concerned about relief from the torments of his "sweaty and itchy" scrotum. The vitiligo was limited to his scrotum. His general health was excellent. Urine negative. Blood Wassermann negative. A photograph of this case is presented.

This group of cases impressed me as being especially interesting because of the element of marked sweating evident in each case; and the more I contemplated and checked these cases with vitiligo in general, the more I was convinced they offered an important clue to the etiology of vitiligo. Such cases, beginning or localized ones, are more likely to suggest the clue. In these cases, the disease began at localities where sweating is normally most profuse, and these we might denominate as places of least resistance; viz., the face and neck, axillae, under the breasts in women and the genito-c.ural region.

However, since the process of sweating involves the entire body surface, the absorption

of sweat products may occur on any part of the body surface; and if the theory is correct, we must expect to find, and do find vitiligo affecting all parts of the skin surface. But these special sweat sites referred to seem to offer a clue to the entire process. The probable rôle of ammonia or ammonium compounds in relation to this theory will be discussed in connection with the chemistry of the sweat.

ANALYSIS OF EVIDENCE

Let us now note how the theory fits in with certain well-known facts observed in connection with this malady.

First: The marked prevalence of vitiligo in the tropics is an outstanding and well authenticated fact incident to vitiligo. Garden found one in 36 cases in India; Forel reported it exceedingly common in Colombia; Croker found only one in 500 cases in London. The sweat theory harmonizes most strikingly with this tropical prevalence of the disease, because we know in these hot climates the natives are profusely bathed in sweat for the greater part of each day. But it is unnecessary to go so far to find abundant evidence of the greater frequency of vitiligo in any hot climate, where naturally the process of sweating is profuse and continuous. During the late war, as a medical officer in the United States Navy, I spent considerable time in the South, particularly in South Carolina, Florida and Louisiana, and I was profoundly impressed by the prevalence there of vitiligo among both the white and colored population. The theory here presented offers a plausible explanation for this should read, "observation", which at the time was as puzzling as it was interesting.

Second: It has been observed by various authorities that vitiligo frequently develops after continued febrile diseases. Here again the theory fits in admirably. Profuse sweating is a common characteristic during some part of the course of most febrile diseases; not only is the patient bathed for days in perspiration, but the perspiration is apt to be especially high in urea content because of increased oxidation incident to the fever. We shall show in discussing the chemistry of sweat that urea is probably the source of the offending agent.

Third: Vitiligo is quiescent during the colder months of the year, when the sweat glands are less active. There are some who will deny this and claim this is only apparent because of absence of tanning during the cold months; the tanning it is true, by contrast, accentuates the depigmented areas on the face or other exposed parts; however, I have observed particularly during the winter months, numerous vitiligoid lesions occurring on the trunk, in different individuals; these lesions on covered parts were not tanned and exhibited merely the usual hyperpigmented borders which grew progressively paler during the cold months. Some of these trunk lesions that were well marked in October were scarcely observable in January. The borders of all lesions examined showed some decrease in pigmentation, also there was no appreciable change in outline nor increase in size of these patches over a period of four months of cold weather when the sweat output was markedly lessened.

THE NEUROTIC ELEMENT

One of the most commonly stated theories is that of a nerve disturbance or that it occurs most frequently in neurotic individuals. Here, I believe we have "the cart before the horse", and in the absence of an intelligent and plausible explanation of the physiopathologic processes involved in this theory, I do not believe it should receive too serious consideration.

If these patients are neurotic, I believe the neuroses develop as a result of, rather than being the cause of vitiligo. Most people naturally wish to appear well before their fellows, and when vitiligo attacks the face or other exposed parts, as it very often does, it readily produces anxiety, self-consciousness and intropectiveness, especially when the patient realizes the futility of treatment. Thus a normal individual may readily become neurotic as a result of his affliction. Chronic incurable physical disabilities are a recognized cause of neuroses.

CHEMISTRY OF THE SWEAT

The study of the chemistry of sweat reveals certain facts which strongly support this theory. The sweat, while a secretion of the

coil glands, is in reality an excretion of waste products and as such analogous to the urine and contains to a greater or lesser degree some of the same constituents. Its specific gravity is about 1005 and when profuse is usually alkaline in reaction. In addition to water, its chief chemical constituents are urea, alkaline chlorides, especially Na CL, phosphates, neutral fats and volatile fatty acids, notably formic, acetic, butyric, lactic, caproic and caprillic, and which, according to Duhring, vary in quantity and quality in different regions of the body.

As the percentage of urea varies in the urine, so we find it varying in the sweat, the urea content of which normally is about 0.1 per cent. Halliburton says: "The urea appears to become quickly transformed into ammonium carbonate," and "in certain cases the skin secretes urea so abundantly that when the sweat dries on the body, it is covered with a coating of urea crystals."

As we consider the various chemical constituents of sweat, urea is the one which at once impresses us as being the logical source of the offending agent. It is decomposed into ammonium carbonate and carbamate; basic, dialyzable salts and it is conceivable that the epiderm, more or less macerated by prolonged sweat contact, may absorb them as such, but what is more probable is that in the presence of moisture these ammonium salts are redissolved, nascent ammonia is liberated and absorbed; the ammonia depigmenting the skin by attacking and bleaching out the melanin of the pigment cells. We are dealing here with NH_3 , a gas, and according to Duhring, "Gases from without pass through the skin with considerable ease, as proved by experiments." Ammonia is widely employed as a detergent and bleaching agent in the trades and in manufacturing and by the so-called beauticians in hair bleaching.

At this point let us consider another interesting case with accompanying photograph, which contributes to the plausibility of this theory.

Case No. 5. A colored woman presented her five months' old daughter at the skin clinic of the Atlantic City Hospital. She sought treatment for numerous white patches appearing on the thighs and buttocks of the infant. As she presented the child, its diaper was wet with urine and strongly

ammoniacal. On removal of the diaper, examination revealed numerous beginning vitiligo patches involving the front and inner aspects of both thighs, the buttocks and the popliteal flexures; in other words, the depigmented areas, twelve in all, were entirely limited to the diaper area. The process of depigmentation, while not yet complete, was well marked and plainly evident. Upon questioning, the mother admitted her neglect to promptly change diapers during the day when wet, and never changed them during the night. She further admitted the diapers were invariably wet in the morning and smelled strongly of ammonia. Aside from the depigmented areas, the child was the picture of health. Its blood Wassermann was negative. We admit we do not know positively what produced the depigmentation in this infant, but from the history and circumstances of the case, we believe it is not only possible, but probable that the nascent ammonia from the decomposed urea of the urine, by repeated and prolonged contact with the tender skin, has been absorbed and caused the depigmentation by bleaching the melanin from the pigment cells. If this correctly explains the vitiligo patches occurring in and limited to the diaper area of this child, we believe it is tantamount to proof of our sweat theory of vitiligo, because similar biochemical processes are involved.

DETERMINING CAUSES

The question may well be asked: Why doesn't everyone develop vitiligo, since the process of sweating is universal? This is a reasonable question and requires a plausible answer, which, however, is not difficult. This is doubtless determined in part by the quantity and quality of the sweat in each individual, partly by the dietary and partly by individual hygienic habits. In this theory, it is our contention that vitiligo results from excessive or profuse sweating and where the urea content is high. It is conceivable that the average skin, up to a certain point, is able to withstand the repeated chemical assaults previously described, and vitiligo develops when this normal skin resistance has broken down. Many people even in warm weather perspire comparatively little or only moderately; these persons will probably escape vitiligo.

Renal and bowel dysfunction may also determine the occurrence of vitiligo in certain persons by producing excessive vicarious sweat with a high urea content. The diet also is probably a determining factor. Those accustomed to a high protein diet would probably be more susceptible to vitiligo because of the greater urea output. The frequency of bath-

ing is likewise an important determining factor. Those who bathe infrequently, allowing the sweat and sweat products to remain on the skin, would appear more likely to develop vitiligo, while those who take their daily shower are unlikely to be affected.

Cannon and Karelitz in their splendid monograph have presented two groups of cases; one in which vitiligo developed after arsenical dermatitis, and the other in which arsenic retention was found in already existing cases of vitiligo, with no associated dermatitis, and in which the source of the arsenic could not be explained. It is quite possible that a severe dermatitis from any cause may induce depigmentation, the literature cites various dermatoses giving rise to a secondary depigmentation, but it is questionable whether they are in reality the progressive malady we recognize as vitiligo; from this viewpoint we are inclined to regard the depigmentation in their cases as a hang-over from the dermatitis rather than due to the arsenic itself.

If vitiligo develops from arsenic alone, with no dermatitis, as their second group of cases indicates, it is but reasonable we should find vitiligo occurring with increasing frequency in luetic patients following prolonged treatment with large doses of the arsphenamines. While not questioning the fact, it is amazing that arsenic retention should exist so extensively in persons entirely unable to account in any way for its presence; and if arsenic retention is so prevalent, it may be found at random in persons showing no vitiligo. This point should be determined.

PROPHYLACTIC TREATMENT OF VITILIGO

If our theory is ultimately proven to be correct, we should be able to offer much in the prophylaxis of vitiligo. Little can be done for the chronic and extensive case, but in recent cases with slight involvement, we should be able to check the process and by preventing extensive disfigurement, also prevent secondary neuroses which may readily occur in sensitive individuals.

The indications would be as follows, viz:

- (1) A low protein diet to reduce the urea output in sweat.
- (2) Stimulate diuresis and bowels to reduce sweat and its urea content.
- (3) Daily ablutions to more quickly remove sweat and its decomposition products from the skin.
- (4) The local application of dilute acidulous lotions to neutralize the alkaline ammonia, also acting as a refrigerant and mild astringent. For this Burow's solution is suggested.

SUMMARY

We have presented the theory that vitiligo may result from absorption by the skin of decomposed sweat products, in particular ammonia, as ammonium carbonate and carbamate, and which, when so absorbed, attack and bleach the pigment from the pigment cells. We have shown how certain authenticated facts harmonize with this theory, and have presented five cases which add further support. Finally, based on this theory, indications for prophylactic treatment are suggested.

STOVARSOL (SPIROCID), ITS USE IN CONGENITAL SYPHILIS A REVIEW OF THE LITERATURE AND A REPORT OF 14 CASES

By BENJAMIN M. JOSEPH, M.D., Jersey City, N. J.

Read before the Section on Pediatrics at the Annual Meeting of the Medical Society of New Jersey, on June 8, 1933

Stovarsol, or spirocid, chemically acetylaminooxyphenylarsonic acid, was synthesized by Ehrlich in 1909 while searching for his ideal spirocheticide. He designated it as preparation number 594 and discarded it because of its toxic effects and its poor results in the treatment of syphilis. Since then the improved

form has been used in amoebiasis, lambliasis, malaria, yaws, chronic malnutrition, and dysentery. The principal trouble had been with its toxicity, but Levaditi and Navarro-Martin showed that stovarsol absorbed from the stomach was less toxic than when absorbed after injection.

Since 1922, stovarsol has been used by many workers and, for the past five years, has acquired a place in the treatment of syphilis in children. With the purification of the drug, its toxic effects were gradually diminished and at present it is past the experimental stage in many of the clinics of Germany and Austria, where it is used routinely.

The effect of the oral administration of stovarsol in weak, premature, or undernourished syphalitic children is excellent. Although there are very few workers who agree upon the same therapeutic amount, yet they all agree that it should be started with a very small dose. For example, Von der Steinen gave infants:

- $\frac{1}{4}$ tablet daily for one week
- $\frac{1}{2}$ tablet daily for one week
- 1 tablet daily for one week.

A week's pause, then one tablet daily for a week, etc., until 10-15 grams were given. This course took from three to four months.

Stovarsol was admitted into new and non-official remedies of the A. M. A. in 1926, but with the specific statement that it was not recommended in the treatment of syphilis.

Its toxicity has been noted by practically all workers, who foresaw the potential disastrous results in its 27 per cent arsenic content.

The toxic manifestations are usually ushered in with a coryza, grippe, and malaise. Fever is usually a constant symptom, and this is followed by a rash which at first is localized, but later extends to the entire body. Accompanying this prodromata may be bronchitis, chills, diarrhea, abdominal pain, adenitis and jaundice. Eosinophilia and albuminuria are fairly constant symptoms. The dermatitis is probably the most frequent manifestation, and may be purpuric or may resemble the rash of measles or scarlet fever.

The cases reported in this paper were treated in the New York Nursery and Childs Hospital Clinic, and were for the most part under the supervision of the Foster Home Service. These children with their mothers or foster-mothers came to the clinic weekly, at which time the weight, temperature and complaints, if any, were recorded on the regular chart. At this visit they received an intramuscular injection of a bismuth salt and they

then received their weekly supply of stovarsol tablets, which were in 0.25 gram. doses.

At the first visit a routine physical examination was done, blood was taken for a serological examination, and x-rays of the extremities were made.

Before instituting the administration of stovarsol to the children, I was mindful of the fact that not only did the mothers object to attempted intravenous therapy, but also the children who, in their attempt to dodge our routine, made our work most difficult to perform. The mothers very often failed to return to the clinic for continuation of therapy.

I decided to use bismodol (Duke) intramuscularly in conjunction with the oral therapy. In this way I was able to ease my conscience and figured that both together would certainly be more beneficial than either alone. What percentage of my favorable results is due to stovarsol, and what percentage to bismodol, is open to question; but to me, after correlating the reports from abroad and from the workers in this country, the results are most satisfactory after careful administration of this arsenic preparation.

If the Wassermann was positive, they got their first injection of bismuth (grains 3), and were started on their stovarsol treatment. The routine was as follows:

- 1st day $\frac{1}{2}$ tablet
- 3rd day 1 tablet
- 5th day $1\frac{1}{2}$ tablets
- 7th day 2 tablets
- Then 2 tablets every other day.

Stovarsol was administered to fourteen individuals. Their ages were as follows:

Under 1 year	1 case
1-2 years	3 cases
2-3 years	3 cases
3-4 years	2 cases
5-6 years	1 case
11-12 years	3 cases
17-18 years	1 case

REPORT OF CASES

Case 1. P. D., male, colored. Age 2 years 5 months at first visit. Wassermann 2 plus on October 26, 1928. Repeated courses of treatment given, and Wassermann repeatedly positive on July 15, 1929, and December 22, 1930. X-ray reveals a periostitis of the long bones. Stovarsol started March 9, 1931. Seventy-one tablets of 0.25 grams each (17.75 grams) and 39 grains of bismuth given.

Wassermann August 24, 1931, negative. Progress fair. Verbal expression somewhat retarded. Weight good.

Case 2. M. C., female, white. Age 3 years 10 months at first visit. Previous history unobtainable. Wassermann 4 plus on June 26, 1931. Stovarsol started on July 6, 1931. Twenty-five tablets of 0.25 grams each (6.25 grams) given, and Wassermann 4 plus on August 3, 1931.

Case 3. J. B., female, colored. Age 1 year at first visit. Wassermann 4 plus on April 17, 1931. Stovarsol started April 27, 1931. Has received 55 tablets (13.75 grams) and 27 grains of bismuth. Wassermann 4 plus on August 3, 1931. Progress unsatisfactory. Child is underweight and does not walk nor talk.

Case 4. G. B., female, colored. Age 1 year at first visit. Wassermann 4 plus on July 8, 1930. Treated with neoarsphenamine. On November 10, 1930, it developed a pruriginous eczema on the face. Treatment was stopped and on January 4, 1931, Wassermann was 4 plus. Stovarsol started on February 2, 1931. After 42 tablets (10.5 grams) and 21 grains of bismuth, the Wassermann became negative on April 3, 1931. A further course of 28 tablets (7 grams) was given and the Wassermann again was negative on August 3, 1931. Total 70 tablets or 17.5 grams stovarsol with no toxic manifestations. Her former symptoms and signs of snuffling, palpable liver and spleen, enlarged Epi-trochlear glands, micropolyadenopathy and periostitis, rönegenologically, has disappeared. Progress good.

Case 5. Maddie F., female, colored. Age 3 years 7 months at first visit. Wassermann persistently positive from July 30, 1929, to December 8, 1930, after neosalvarsan injections. Stovarsol started on December 15, 1930. Sixty-four tablets (16 grams) and 27 grain Bismuth given, and Wassermann 4 plus on April 3, 1931. A further course of 65 tablets (16.25 grams) and 30 grains of bismuth given and Wassermann 3 plus on August 3, 1931. Total 129 tablets (32.25 grams) and 57 grains of bismuth given with no toxic results. Serological change slow but general physical progress good.

Case 6. Muriel F. Age 2 years 7 months at first visit. Wassermann persistently positive from August 2, 1929, to December 8, 1930, at which time it is 3 plus. Stovarsol started December 15, 1930. Sixty-four tablets (16 grams) and 24 grains of bismuth given. Wassermann 2 plus. A further course of 65 tablets (16.25 grams) and 33 grains of bismuth given, after which the Wassermann is 2 plus on August 3, 1931. Total 129 tablets (32.25 grams) and 57 grains of bismuth administered with no toxic symptoms. Slow serological change but general physical condition is good.

Case 7. J. R., female, white. Age 1 year 1 month at first visit. Stovarsol started December 1, 1930. Eighty-two tablets (20.50 grams) and 39 grains of bismuth given after which Wassermann is 3 plus. A further course of 80 tablets (20 grams) and 42 grains of bismuth given, after which Wassermann is doubtful August 3, 1931. Total 162 tablets (40.50 grams) and 81 grains of bismuth administered with no toxic effects. Progress satisfactory and weight good.

Case 8. R. A. S., female, white. Age 6 years at

first visit. Original anti-luetic treatment started on October 30, 1929, after which she has had strongly positive Wassermans. Stovarsol started on December 15, 1930. Seventy-two tablets (18 grams) of Stovarsol and 33 grains of bismuth given, after which Wassermann is 1 plus. A further course of 74 tablets (18.50 grams) and 42 grains of bismuth given and on August 3, 1931, Wassermann is doubtful. Total 146 tablets (36.50 grams) and 75 grains of bismuth administered with no toxic results. General condition good.

Case 9. J. D. B., male, white. Age 2 years at first visit. Had been treated by a private physician for congenital Lues. At the time of the first visit, the Wassermann was negative. Stovarsol given nevertheless and after 27 tablets (6.75 grams) and 12 grains of bismuth, the Wassermann remains negative August 3, 1931.

Case 10. K. M., female, white. Age 11 years at first visit. Since November 25, 1925, has had anti-luetic treatment and at the time of the stovarsol treatment, the Wassermann was 3 plus. 55 Tablets (13.75 grams) and 30 grains of bismuth given after which the Wassermann is negative. Another course of 63 tablets (15.75 grams) and 42 grains of bismuth administered, after which, the Wassermann persists negative. Total 118 tablets (29.50 grams) and 72 grains of bismuth administered with no toxic results. Progress good.

Case 11. R. M., female, white. Age 17 years 8 months at first visit. Has had anti-luetic treatment since 1925, and at start of stovarsol treatment on December 22, 1930, Wassermann is 3 plus. 55 Tablets (13.75 grams) and 30 grains of bismuth given after which the Wassermann is still 3 plus. A further course of 50 tablets (12.50 grams) and 36 grains of bismuth administered, after which, the Wassermann is negative. Total 105 tablets (26.25 grams) and 66 grains of bismuth given with no toxic results.

Case 12. R. P., female, white. Age 11 years 2 months at first visit. Has had a positive Wassermann since 1926, at which time she had an alopecia. By 1927, she was completely bald. Wassermann 3 plus on November 24, 1930. Stovarsol treatment started on December 8, 1930. 63 Tablets (17.75 grams) stovarsol and 33 grains of bismuth given, after which the Wassermann is negative. A further course of 55 tablets (13.75 grams) and 42 grains of bismuth given, and the Wassermann is persistently negative. Total 118 tablets (29.50 grams) stovarsol and 75 grains of bismuth given with no toxic manifestations. The hair on the scalp is slowly returning. The eyelashes are quite long.

Case 13. A. J., male, colored. Age 4 months at beginning of treatment. Wassermann 4 plus on July 30, 1930. Stovarsol started November 24, 1930. 16 Tablets (4 grams) stovarsol with 12 grains of bismuth given and Wassermann was negative on December 8, 1930, April 3, 1931, and on August 10, 1931. Excellent progress.

Case 14. N. S., male, white. Age 13 years at first visit. Wassermann 4 plus on April 13, 1931. Stovarsol started on May 11, 1931. 58 Tablets (14.5 grams) stovarsol and 30 grains of bismuth given; after which Wassermann was 3 plus on August 3, 1931. Non-toxic results. General condition good.

ABDOMINAL SURGERY IN INFANCY AND CHILDHOOD

By EDWARD J. DONOVAN, M.D., New York City

Read before the Section on Pediatrics of The Medical Society of New Jersey at its Annual Meeting in Atlantic City, June 8, 1933

Most of the conditions encountered in the abdominal surgery of infancy and childhood are the same pathological processes as found in adults except that they are modified by conditions peculiar to early life. The surgery of early infancy is, in a large measure, due to or the result of some error in development. Infection plays a very small part in the abdominal surgery of the first year, but after this time, it forms the background of many pathological abdominal conditions as it does in adult life. With the exception of the malformations of the intestinal tract, pyloric stenosis and idiopathic intussusception as found in infants are two conditions for which we do not find a prototype in adult life.

The conditions that modify abdominal surgery in infants and children are often not detrimental in character. For example, the absence of speech in an infant deprives the examiner of the subjective help that he obtains from an adult, but to counterbalance this, it makes him observe more carefully and judge more keenly.

Growth and development affect the course of many diseases in infancy and childhood. It is this factor which often makes disease sudden in its onset, short in course and more intense in its manifestations. It is this also which comes to the aid of the surgeon perhaps in overcoming by growth the malignment of a fracture or the spontaneous healing of an incisional hernia.

No operative skill can overcome the bad results of delayed diagnosis. A child with a ruptured appendix and general peritonitis in the hands of a master surgeon probably does not have as good a chance of recovery as one who has had his appendix removed before rupture perhaps by someone far less skillful. Early diagnosis is often very difficult, but it can usually be made if the examiner follows a fairly definite plan of examination. He must seize his opportunities as they present themselves, be ever ready to change his plan of attack and be gentle but thorough at all times.

Some of the old established customs of preparation for operation have fortunately fallen into discard. Starvation and purgation have no place in the modern surgical procedure. The ability of an infant to stand starvation has previously been underestimated, and now we fully appreciate the importance of body fluids both before and after operation. Purgation not only wastes valuable body fluids but by irritating the intestinal tract definitely increases postoperative discomfort. We now aim to build up the body fluids before operation and maintain this fluid balance during the most critical part of the child's illness. This may be done by giving fluids, preferably saline and glucose, by infusion, hypodermoclysis or intravenous drip. We have been able to give intravenous drip infusion to small infants for as long as five days. Transfusion of whole blood is one of the greatest aids the surgeon has. The smallest infant may have 20 cc. of whole blood per kg. of body weight by any of the modern methods. One must be careful in giving infusion or transfusion to any child with a complicating pulmonary lesion because of the danger of overloading the right heart. Saline or glucose paraenterally may be used to keep a child free from ketosis for as long as a week.

It is not unusual to find that an infant or child has an unexplained temperature at about the time you had planned to operate upon him. This may be due to dehydration, an acute ear, a red throat or the onset of one of the exanthemata. The temperature often is of no consequence, but it is a safe rule to postpone, for a few hours at least, any elective operation upon an infant or child who has an unexplained temperature.

Infants and children tolerate ether anesthesia very well. It has been our practice to use ethyl chloride for induction followed by open drop ether. We have practically no postoperative respiratory infections that we can attribute to ether. The indications for local anesthesia, whether it be infiltration, field block or spinal, are very few, in fact, necessary only in the

presence of an acute respiratory infection when surgery needs to be done. Avertin as a basal anesthetic has many uses in children, and, combined with local anesthesia, is often most satisfactory.

Regarding actual surgical procedure, the most rigid asepsis must be practiced at all times. Children are very susceptible to infection, and every means at hand should be used to guard them against it. The operation should be carefully planned and executed with as much dispatch as is consistent with gentleness, careful handling of tissues and strict hemostasis. The temperature of the operating room should be about 72 degrees; the child should be protected from unnecessary exposure; the body heat maintained during operation. Everything should be ready to start the operation before the induction of the anesthesia so as not to keep the child under anesthesia longer than is necessary. At the conclusion of the operation, the child should have any moist coverings changed for dry ones before leaving the operating room. He should be placed in bed with his head lowered until he has fully recovered from the anesthetic. A tank of oxygen and tongue forceps should always be at hand in the recovery room. No child should be left alone until completely recovered from the anesthetic.

Plain fluids are allowed as soon as nausea and vomiting have ceased, and children may be given tap water or glucose by rectum immediately after operation. If there is any tendency to acidosis, infusion or clyses may be started before the child awakes. As a rule, it is no trouble to force fluids in children after operation. Solid food may be given on the second or third day after operation. All incisions should be dressed every two days because of the danger of contamination from soiled diapers.

Most of the usual postoperative complications of adult surgery are entirely lacking in children. Pulmonary embolism is practically unheard of. Postoperative pneumonia is much less frequent, postoperative retention of urine is never troublesome, and cathartics after operation are hardly ever necessary. We need to be concerned a little more about postoperative rupture of incisions in children than we do in adults, particularly in those children who

are poorly nourished or who develop measles or whooping cough soon after operation. To guard against this complication, we make it a practice to use retention sutures for the deep layers, particularly for rectus incisions, and to take particular care to get an accurate layer closure of all incisions. Most children will unconsciously keep an injured part at rest, and, when once taught to lie quietly in bed, they will remain so indefinitely.

In conclusion, therefore, we may say that infants and children are excellent patients as a rule and splendid subjects for surgical procedures that are carefully planned and as skillfully executed as is consistent with the utmost care and gentleness in handling tissues. The surgical approach to the diseased organ should be as direct as possible as there is practically no indication in children for the so-called exploratory laparotomy of adults. Careful hemostasis is very essential, and the careless, rough, dragging upon organs and blunt dissection which in an adult result in a stormy convalescence may prove fatal for a child. There is no excuse in our day for a surgeon's performing any elective major surgery on a child without determining first that the child is in the best possible physical condition. Many a skillfully executed operation has been a failure because the child was dehydrated, anemic, exhausted, or otherwise not in condition to withstand it. There is a definite relation between the state of nutrition, the general condition of the child and the convalescence from any operation. We must ever be mindful that there is a very definite limit to the amount of surgery a child can stand. They resist powerfully to a certain point, but the fall is precipitate.

In surgery of infancy and children, one finds many unusual conditions particularly among the malformations of the gastrointestinal tract. I have selected three of these conditions as being particularly interesting from a surgical standpoint. These are volvulus of the small intestine in the newborn, congenital diaphragmatic hernia and Hirschsprung's disease. In the last three years at the Babies' Hospital, New York, we have had a small series of each of these conditions which are unusual enough to be worth reporting briefly to you.

We have had three cases of volvulus neonat-

torum aged 10, 12, and 12 days respectively. All three cases had vomited since birth, all developed acute intestinal obstruction in the hospital and had to be operated upon as emergencies. The condition at fault in volvulus neonatorum is that the ascending colon does not fuse to the parietal peritoneum, and, therefore, being freely movable, predisposes to volvulus. You may remember that a large part of the development of the midgut loop (that portion of the intestinal tract from the ampulla of Vater to midtransverse colon) takes place outside the abdomen. This later passes back inside the abdomen, the caecum and appendix being the last part to return. When rotation is complete, the caecum and ascending colon pass to the right lateral quadrant where the ascending colon fuses to the posterior parietal peritoneum and remains fixed there.

The findings at operation in all of these cases were quite uniform. There was no fusion between the gastrocolic omentum and the transverse mesocolon. The caecum, appendix and ascending colon were in the left upper quadrant of the abdomen. The small intestine from the duodenojejunal junction to the ileocaecal junction was turned three or four complete turns in a clockwise direction around the superior mesenteric vessels and root of the mesentery as an axis. Volvulus was reduced by turning it in a counterclockwise direction the same number of turns. The caecum and ascending colon were brought down and attached to the parietal peritoneum in the right lateral quadrant. Two of the three cases survived and are well 19 and 22 months postoperative and are free from symptoms. One case died twelve days after operation from inanition and gastroenteritis.

We have also successfully operated upon three congenital diaphragmatic hernias in the past three years. In one case, aged 4 months, the stomach was completely in the thorax through the large oesophageal opening. In this case the oesophagus was short and when the stomach was brought down to the abdomen, it sprang back through the oesophageal opening as though attached to a rubber band. The oesophageal opening was closed around the oesophagus, but a very small part of the cardiac end of the stomach went back through

the opening because of the short oesophagus. The child's symptoms have been relieved and she is doing very well one and one-half years later. The other two cases, 4 and 6 months old respectively, were perfect results. Subcostal abdominal approaches were made in all cases. Both openings were through the foramen of Bochdalek (the posterior costa-vertebral foramen), one case in the right side and one case in the left. In the right-sided hernia, the following structures were in the chest: all the small intestines from the duodenojejunal junction down, the caecum, ascending colon and the right half of the transverse colon. The structures were easily reduced and the opening in the diaphragm was closed with heavy silk. The child is entirely free from symptoms one and a half years after operation. The left-sided hernia, in addition to the structures mentioned above, had the spleen and splenic flexure of the colon also in the thorax. This child is now two years postoperative and has remained entirely free from symptoms.

We have resected the presacral nerve and superior mesenteric sympathetic nerves in three cases of Hirschsprung's disease with very striking results. One case had had 50 cm. of sigmoid removed previously in another hospital for the same condition with no relief. According to Rankin, Hirschsprung's disease is due to neuro-muscular dysfunction of the colon. There are three factors at work in Hirschsprung's disease which are causing the lack of expulsive force in the colon. There is inhibition to muscular tone, dilatation of the colon and spasm of the internal sphincter ani. The first two conditions may be corrected by section of the inferior mesenteric nerves. The spasm of the internal sphincter is relieved by section of the presacral nerve. This operation, therefore, restores muscular tone and relieves the obstruction of the internal sphincter. All three cases had spontaneous bowel movements before leaving the hospital on the 14th day postoperative. None of these cases had ever had spontaneous bowel movements before, but often had gone as long as seven days without a bowel movement. All cases now one and one-half years to 4 months postoperative have daily, normal bowel movements. They have all gained weight and are very satisfactory results.

ECTOPIC PAROXYSMAL TACHYCARDIA

By JOHN WYCKOFF, M.D., New York, N. Y.

Abstract of an address before the Section on Medicine and Pediatrics of the Academy of Medicine of Northern New Jersey, April 19, 1934, in Newark

Dr. Wyckoff opened his talk with a cursory consideration of the various origins of an ectopic rhythm in the sino-auricular node, auricular tissue, auricular-ventricular junctional tissue, and ventricular musculature. Ectopic paroxysmal tachycardia is an uncommon condition in public hospital work. Less than one per cent of Bellevue Hospital patients have been found to have this abnormality.

The etiology of the arrhythmia is not well understood, but 50 per cent of the cases have an underlying organic cardiac lesion, and 15 per cent have a toxic basis.

About 30 per cent of cases of arrhythmia are caused by some disorder of the vegetative nervous system; and among them may be placed a large number of women suffering from this condition during menopause. Otto and Gold have demonstrated that the intravenous injection of adrenalin will produce an attack in patients who are known to have had attacks previously. The presence of paroxysmal tachycardia in a neurotic patient is usually superimposed upon an otherwise normal heart.

Paroxysmal tachycardia may also be brought about by chloroform anesthesia.

Dr. Wyckoff next described the *supraventricular* (nodal and auricular) variety of this condition. The attack begins and ends abruptly. The rate is very constant, and varies from 120-215 per minute. It may last from a few seconds to a year, and can usually be stopped by carotid sinus stimulation. The origin of the ectopic rhythm can be determined only by an electrocardiogram. With very rapid rates the institution of a heart block may cause the ventricles to beat at one-half to one-fourth the rate of the auricles.

Next, the speaker considered the *ventricular* variety of this arrhythmia. Here the paroxysms are shorter, less regular, and usually of serious prognostic import. The ventricles may beat first; and a coincident retrograde block at the junctional conductive tissue will permit the auricles to beat at a completely dissociated rate from the ventricles. Canby Robinson showed that this ventricular paroxysmal tachycardia is frequently associated with coronary occlusion. Dr. Wyckoff pointed out that this condition is also found in digitalis poisoning, and in terminal stages of auricular fibrillation where digitalis has lost its efficacy. Rarely is it found upon a neurogenic basis as in the *supraventricular* variety.

Dr. Wyckoff showed a number of excellent elec-

trocardiograms which clearly demonstrated the characteristic features of each of the types described.

He next considered the *symptoms*. The patient may experience breathlessness, anxiety, perspiration, palpitation. When the condition is superimposed upon an organically damaged heart, anginal attacks may be present. Rarely, temporary blindness, syncope, or even epileptiform attacks may supervene. To bring about syncope, or even pulmonary edema in this condition, a rate close to 200 without a coincident block must be present.

Occasionally *pulsus alternans* may occur; and the condition is masked unless attention is paid to the heart rate of the electrocardiogram.

The speaker next succinctly considered the *differential diagnosis* in ectopic paroxysmal tachycardia. He showed how epilepsy, Stokes-Adam syndrome, and hyperthyroid might easily be distinguished from this condition.

In a consideration of the *prognosis*, Dr. Wyckoff emphasized that the outlook is excellent unless the heart condition is superimposed upon an organically damaged heart; and that the ventricular variety is almost always of unfavorable significance.

Finally, the speaker considered the problem of *treatment*. Psychogenic management is most gratifying in the neurogenic variety. Sixty per cent of the cases will return to a normal rate suddenly with various methods of vagal stimulation. Among the procedures used to bring about such an effect are carotid sheath pressure, ocular pressure, straining as if at stool, holding the breath, or the voluntary induction of vomiting.

Apomorphine and pilocarpine are occasionally efficacious. Digitalis (one and a half cat units), or complete digitalization, may terminate an attack. Crystalline strophanthin or quinidine are not infrequently successful. Intravenous quinidine in doses of 0.33-0.6 gr., may occasionally terminate an attack, but this procedure is dangerous and has been known to have caused fatalities.

Recently mechohol (acetyl-beta-methylcholin) has been found to stop a great majority of attacks of supra ventricular tachycardia when given intravenously. If the drug alone will not stop the attack, the drug in combination with carotid pressure is almost sure to do so. The usual efficacious dosage is 50 milligrams.

STATE SOCIETY ACTIVITIES

THE PHYSICIANS' LIEN LAW An Amendment to the Hospital Lien Law

Senate bill No. 136 amending the "Hospital Lien Act", which became a law on April 30 with Governor Moore's signature, is of vital interest to every member of The Medical Society of New Jersey. According to this Act, if a person is injured through the negligence of some other person and obtains a judgment against the person responsible for the injury, or where a settlement is made in favor of the injured person, the *doctor* or *hospital* supplying the treatment may obtain a lien upon that judgment or settlement, provided the doctor or hospital takes certain steps which are specified in the law, as follows:

SECTION 1. STEPS TO BE TAKEN BY THE DOCTOR WITH EACH CASE TREATED

1. Prepare a written notice containing:
 - a. The name and address of the injured person.
 - b. The date of the accident.
 - c. The name and address of the physician.
 - d. The name of the party alleged to be liable for the injury, if it is known.
2. File a copy of the notice with the County Clerk of the county in which the injuries occurred.
3. Mail to the party alleged to be responsible for the accident, if the name and address are known, the following information:
 - a. A copy of the notice.
 - b. The date of filing the notice with the County Clerk.

These are legal requirements, and must be scrupulously observed in order that the doctor or hospital may maintain an action for the recovery of a claim.

The law requires that the physician or hospital shall file the notice "Prior to the payment of any moneys to such injured person or his legal representative as compensation for such injuries". Prompt action by the physician or hospital is therefore necessary, for offers of settlement are sometimes made and accepted before the injured person has time for reflection.

SECTION 2. PRELIMINARY STEPS BY THE COUNTY MEDICAL SOCIETY

Before a physician may recover any claim under the law, the County Medical Society must take the following actions in order to

set up the proper means for carrying out the law:

1. It shall determine upon a reasonable schedule of charges for the treatment of the injuries or conditions which are likely to be treated.

2. It shall file the schedule with the County Clerk.

3. It shall insert an advertisement in a newspaper circulating in the county, giving notice of a public hearing to be held by a Judge of the Court of Common Pleas in order to determine the reasonableness of the schedule of charges.

4. It shall conform to the standards and requirements of the Medical Society of New Jersey. (This subdivision is not in the law, but is a requirement of the State Medical Society; see Section 5.)

SECTION 3. STEPS TO BE TAKEN BY THE JUDGE

The following procedure shall be observed by the Judge:

1. He shall hold the public hearing regarding the reasonableness of the charges.

2. If he determines that the charges are reasonable, he shall make an order to such an effect and shall file it with the County Clerk.

The law reads:

"The schedule of charges filed as in this section provided may be introduced as evidence of the reasonable value of the service so performed, but in no event shall any charge be made in excess of the schedule so filed and approved."

SECTION 4. DUTY OF THE COUNTY CLERK

Section five of the law requires the County Clerk to perform the following duties:

- "1. Provide a suitable well-bound book, to be called 'The Physician and Hospital Lien Docket,' in which he shall enter:

- "a. The name of the injured person.

- "b. The date of the accident.

- "c. The name of the physician and/or hospital or other institution making the claim.

- "2. Make a proper index of the same in the name of the injured person."

SECTION 5. ACTION BY THE STATE MEDICAL SOCIETY

In order to attain promptness of action and uniformity of results, President Quigley has

appointed a special committee of The Medical Society of New Jersey to draft a maximum and minimum fee schedule for the advice and guidance of the County Medical Societies in preparing their official schedules. Each County Society will receive a copy of the State Society schedule through its Secretary, and shall appoint a special committee which shall take the following action:

1. Draft a fee schedule in conformity with that of the State Medical Society.
2. Submit the schedule to the Special Committee of the State Society for approval.
3. File the approved schedule with the County Clerk, as required by Section 2.

The members of this Special Committee of The Medical Society of New Jersey are as follows: Elmer Peter Weigel, Chairman, Union;

Thomas B. Lee, Camden; Homer T. Silvers, Atlantic; Samuel Sica, Mercer; Irving J. Fort, Essex; William L. Yeaton, Hudson; Thomas J. Summey, Burlington; Joseph A. Visconti, Hudson; Inglis F. Frost, Morris.

COMMENT

The law is written in a form which is unusually clear and logical, and which may be easily read and understood by any physician. Its requirements are entirely reasonable and may be readily observed. The official copy of the law is herewith reproduced for the benefit of the physicians and hospitals of New Jersey, except that the numbering of the lines is omitted because the form of the six-inch lines of the original cannot be reproduced in the three-inch column of The Journal without the use of a type too small to be legible.

THE TEXT OF THE PHYSICIANS' LIEN LAW

The full text of the amended Senate Bill No. 136, which was passed by both Branches of the Legislature and was signed by Governor Moore on April 30, 1934, becoming Chapter 109 of the Public Laws of 1934 of New Jersey:

AN ACT to amend the title and body of an act entitled "An act to provide for liens in favor of hospitals and other charitable institutions furnishing care, treatment, and maintenance of persons injured in accidents upon the rights of action, claims or demands of such injured persons against other persons or corporations for damages on account of negligence causing the injuries and upon the proceeds of the settlements of any such claims or demands," approved April seventh, one thousand nine hundred and thirty, as amended by acts approved April sixteenth, one thousand nine hundred and thirty and April twenty-seventh, one thousand nine hundred and thirty-one.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. The title of the act of which this act is amendatory is hereby amended so as to read as follows:

An act to provide for liens for medical and surgical treatment and hospital care, treatment and maintenance of persons injured in accidents in favor of persons licensed by law to practice medicine and surgery in this State and hospitals and other charitable institutions upon the rights of action, claims or demands of such injured persons against other persons or corporations for damages on account of

negligence causing the injuries and upon the proceeds of the settlements of any such claims or demands.

2. Section one as amended of the act of which this act is amendatory is hereby amended so as to read as follows:

1. Every person licensed to practice medicine and surgery in this State, hereinafter referred to as a physician, and every charitable association, corporation or other institution maintaining a hospital in the State of New Jersey supported in whole or in part by private charity, or owned, operated and/or maintained by any municipal or county board and/or body, and hereinafter referred to as a hospital, shall have a lien upon any and all rights of action, suits, claims, counterclaims or demands of any person treated by any such physician or admitted to any such hospital and receiving treatment, care and maintenance therein, on account of any personal injuries received in any accident as the result of the negligence of any other person or corporation, which any such injured person may or shall have, assert or maintain against any such other person or corporation for damages on account of such injuries, for the amount of the reasonable charges of such physician for medical and/or surgical treatment and of such hospital for treatment, care and maintenance of such injured person at ward rates in such hospital up to the date of payment of such damages; *provided*, a notice in writing containing the name and address of the injured person, the date of the accident, the name and address of the physician and/or the name and location of the hospital, and if known the name of the person or persons, firm or firms, corporation

or corporations alleged to be liable to make compensation to such injured person for the injuries received, shall be filed in the office of the county clerk of the county in which such injuries shall have occurred, prior to the payment of any moneys to such injured person or his legal representative as compensation for such injuries. After the filing of such notice it shall be the duty of the physician and/or hospital to mail, postage prepaid, a copy of such notice, with a statement of the date of the filing thereof to the person or persons, firm or firms, corporation or corporations, alleged to be liable to make compensation for the injuries sustained by such injured person, if their name and address shall be known. The claim of any such physician may be included in and made a part of the claim of any such hospital. The reasonable charges for which a lien may be claimed by a physician or surgeon shall not exceed the charges specified for the services performed in the schedule of charges filed by the county medical society in the county where the services are performed and the lien filed or made applicable therein as hereinafter provided. The component county medical society of the Medical Society of New Jersey shall determine upon a reasonable schedule of charges, which said schedule and any subsequent charges, amendments or additions thereto shall be filed with the county clerk of the county. Before any such schedule of charges shall become operative, such society or any physician interested in the creation and establishment of such charges shall give thirty days' notice by public advertisement, which advertisement shall be inserted in a newspaper circulating in such county, and upon the expiration of such period a judge of the court of common pleas of the county shall hold a public hearing at which time evidence may be offered by any party in interest as to the reasonableness of the schedule of charges so filed as aforesaid. If the said court of common pleas shall be satisfied of the reasonableness and sufficiency of the charges, he shall make an order to such effect and file the same with the county clerk and in any suit to enforce a lien or to recover compensation, the schedule of charges filed as in this section provided may be introduced as evidence of the reasonable value of the service so performed but in no event shall any charge be made in excess of the schedule so filed and approved.

3. Section two of the act of which this act is amendatory is hereby amended so as to read as follows:

2. The lien of any such physician and/or hospital shall attach to any verdict, report, de-

cision, decree, award, judgment or final order made or rendered in any action or proceeding in any court of record of New Jersey, or any public board or bureau, in any suit, action, or proceeding brought by such injured person, or by the estate of such injured person in case of deaths as the result of such injuries, against any other person or corporation for the recovery of damages or compensation on account of injuries received in any such accident, as well as to the proceeds of any settlement thereof, or the settlement of any such claim or demand effected by any such injured person with any other person or corporation whose negligence is claimed or alleged to have been the cause of the said accident or effected with any other person or corporation on account thereof.

4. Section three as amended of the act of which this act is amendatory is hereby amended so as to read as follows:

3. After the filing of the notice as herein provided, no release of any judgment, claim or demand by such injured person shall be valid or effectual as against such lien, and the person or persons, firm or firms, corporation or corporations making any payment to such injured person or his legal representative as compensation for the injuries sustained shall for a period of one year from the date of such payment as aforesaid remain liable to such physician and/or hospital for the amount of the reasonable charges due at the time of such payment as aforesaid, to the extent of the full and true consideration paid or given to the injured person, and any such physician and/or hospital may, within such period, enforce his and/or its lien by a suit at law against such person or persons, firm or firms, corporation or corporations making any such payment.

5. Section four as amended of the act of which this act is amendatory is hereby amended so as to read as follows:

4. Every county clerk shall, at the expense of the county, provide a suitable, well-bound book, to be called the physician and hospital lien docket, in which, upon the filing of any claim under the provisions of this act, he shall enter:

The name of the injured person, the date of the accident, the name of the physician and/or hospital or other institution making the claim.

And the said clerk shall make a proper index of the same in the name of the injured person; and such clerk shall be entitled to twelve cents for filing each claim, and at the rate of eight cents per folio for such entry made in the lien docket and six cents for every search in the office for such lien claim.

6. This act shall take effect immediately.

PHYSICIAN'S LIEN NOTICES

Forms of notices to be given by a physician called to treat an accident case in accordance with Chapter 109 of the Laws of 1934, have been considered by the Special Committee to the Welfare Committee on the physicians' Lien Law. The Committee suggests that the physician shall use the following form in filing his original notice:—

FORM 1.

Original Notice of Accident to Be Filed by the Physician as Soon as Possible After He Has Been Called to a Case

.....
Place	Date
To the County Clerk of .....County, New Jersey	
(County in which the accident occurred)	
Full name of injured person.....	
Address of injured person	
Date of Accident	
Name of County in which accident occurred.....	
Name of Physician	
Address of Physician	
Name of person, firm, or corporation, if known, alleged to be liable to make compensation for the injuries	
Name of Insurance Company, if known	
Address of Insurance Company, if known	
Full amount of physician's bill, if known	
A copy of my bill will be mailed to you when the treatment of the patient is completed.	
Lien filed with County Clerk this day of, 1934.	
(Signed), M.D.	

The Committee suggests the following form of a letter to be used in transmitting the notice to the County Clerk:

FORM 2

Notice of Transmissal and Fee

To the County Clerk,
County of,
....., New Jersey

Dear Sir: Re:

Enclosed please find twenty-six cents, statutory fee, for filing the attached notice of the physician's and surgeon's lien, in accordance with Chapter 109 of the Laws of New Jersey, of 1934, effective April 30, 1934.

Very truly yours,
(Signed), M.D.

The payment of the statutory fee is obligatory in order to complete the evidence that the physician has complied with every detail of the law.

The Committee suggests the following form of a letter to be sent by the physician to the person liable for his claim under section one of the Law:

FORM 3

Information to Defendant

Dear Sir:

Herewith is a copy of the lien which is filed with the County Clerk of the County of, in accordance with Chapter 109 of the Laws of 1934, effective April 30th, 1934, giving a lien to physicians and surgeons for medical and surgical treatment in accident claims based on negligence.

The physician's bill for services rendered must be paid before making final settlement with the injured.

It is suggested that, if you are insured, you forward this letter to your insurance carrier.

Very truly yours,
(Signed), M.D.

THE ANNUAL MEETING, 1934

The 168th Annual Meeting of The Medical Society of New Jersey, which was held in Haddon Hall, Atlantic City, on June 5, 6 and 7, 1934, may properly be described as interesting, constructive, educational, and inspirational. New features were introduced in the conduct of its business, and new records set for efficiency and smoothness in carrying out the programs. The registered attendance was 200 delegates, 349 other physicians, and 422 visitors, consisting largely of the members of the Woman's Auxiliary. The total number registered was 971, the largest in eleven years. The attendance at the closing general session was one hundred.

This article will consist of unofficial comments on the more prominent phases of the meeting. A complete account of the meeting will be contained in the "Official Transactions", which will be published as a supplement to *The Journal* as soon as the stenographic reports can be transcribed and edited—probably in August.

THE PRESIDENT'S YEAR

Each year of administration of The Medical Society of New Jersey, like that of the Federal Government, is known as the President's. This is peculiarly true of the past year because of the action of the Trustees taken on June 7, 1933, in making the President in fact, as well as in name, the responsible head of all departments of the Society work. The new system is an evolution of the older system of independent action into that of coöperation and coördination which began when the *Welfare Committee* was formed in 1921. This Committee consists of thirty-five members, which function through sub-committees which deal promptly with new problems as soon as they arise. In this way the Society has been able to act without waiting for the slower process of action through a few standing committees whose members are already giving their full quota of attention to routine duties.

This year has been a "President's Year" to an unusual extent; but it has also been the year of the county society and the individual members. Activity has permeated the whole organization because of the close relation of the component county societies to the central state organization.

The activities of the past year have demonstrated the superiority of the New Jersey system of medical organization whose efficiency is largely the result of three factors:

1. The appointment of a sub-committee of the Welfare Committee to develop a method of dealing with each important situation as soon as it arises.

2. The appointment of a similar committee in every county society.

3. The continuing activity of the state committee in advising and assisting the county committees, and in following up the development of the new activity in every part of the state.

The new system is like that of the Federal Army whose field activities are directed by a General Staff empowered to deal with emergency conditions as soon as they arise. An example of such an emergency condition is that of the situation created by the Physicians' Lien Bill. When this became a law on April 30, 1934, President Quigley immediately appointed a special committee to the Welfare Committee to set the plan into operation by the component county societies, each of which, like the regiment of an army, has a large latitude of action in details, but all working for a common end.

HOUSE OF DELEGATES

The most evident result of the centralization of effort was the efficient functioning of the House of Delegates. The meeting of the House actually began early in April when each officer and chairman began the preparation of his annual report, which was published in *The Journal* of May—the twenty-six reports filling forty pages. Every member of the Society received a copy of the report, and therefore came to the meeting with a definite knowledge of all phases of the work of the Society. When the House of Delegates convened, the room was filled with members who remained throughout the session. Each officer and chairman of committee was given the opportunity to add a brief comment to his printed report.

The second step was the assignment of the reports to six reference committees, each of which announced a definite time and place for its meeting when it would hear the comments, criticism, and suggestions which any member wished to present. This plan afforded every member the opportunity to be heard on any phase of the work of the Society, with the assurance that he would be given that respectful hearing which would be impossible if the time of the session was occupied in listening to the readings of lengthy reports, and the expression of opinions regarding smaller details.

The third step was the delivery of the opinions of the reference committees regarding the recommendations contained in the annual reports. These opinions had been carefully considered by each reference committee, acting as a deliberating jury. These opinions were adopted by the House in almost every instance. The system worked to the satisfaction of all the members if one may judge by their favorable comments and the absence of criticism of the method.

Reprints of the reports had been made with the following description on each title page:

"This pamphlet is one of three important documents issued by The Medical Society of New Jersey, as follows:

"1. Annual Reports of Officers and Committees to the House of Delegates, June 5, 1934.

"2. Transactions of the House of Delegates, June 5-7, 1934.

"3. Official Membership List of May 1, 1934.

"Clip these three documents together and preserve them for future reference."

Two of these documents have already been issued; while the third—the "Official Transactions"—will be issued as soon as it can be prepared. They will be invaluable to every officer and committeeman of every county society, and to every member who wishes to be informed regarding the work of the organization, which is of vital interest to his professional welfare.

UNWRITTEN IMPRESSIONS

The efficiency of the functions of the Annual Meeting as disclosed by the unwritten impressions which the members *carry away from the meeting*, rather than by those which they *brought to it*. The common impression which the members took to their homes was that the solution of the newer problems which face the medical profession of New Jersey is the concern of every individual member of the Society, and will demand his earnest thought and consideration over a period of years. The inspiration to attempt the solution of those problems is the outstanding result of the Annual Meeting.

ELECTION OF OFFICERS

The election of officers on the second day of the Annual Meeting required an unusual length of time owing to the nominations from the floor. However, agreements were reached regarding the offices to be filled, and the contest was conducted in a friendly way.

The President, Dr. Lancelot Ely, had already been chosen, since under the new system he is elected a year in advance of his assumption of office. The First Vice-President, Dr. Marcus W. Newcomb, of Brown's Mills, was advanced to the position of President-Elect; and the Second Vice-President, Dr. Francis E. Haussling, of Newark, to First Vice-President; while Dr. Spencer T. Snedecor, of Hackensack, who had served as Chairman of the Medical Advisory Committee to the State Emergency Relief Administration, was chosen Second Vice-President. Dr. J. B. Morrison, of Newark, was unanimously continued as Secretary after years of service in that office, and Dr. Wells P. Eagleton, of Newark, was similarly honored with reelection as Trustee. Dr. Frederic J. Quigley, the retiring President, was chosen Trustee to fill the unexpired term of Dr. Charles B. Smith, of Washington, who died on December 19, 1933. Dr. Harold B. Disbrow, of Lakewood, and Dr. Andrew F. McBride, of Paterson, were reelected Trustees.

Dr. Elias J. Marsh, of Paterson, was unanimously reelected Treasurer.

SCIENTIFIC MEETINGS

Twelve scientific meetings were held—five general meetings, and seven of the sections.

MEETING ON ECONOMICS

The first general meeting was held on the evening of Tuesday, June 5, when the newer economic phases of medical practice were presented by two guest speakers—Dr. Frederic Elliott, Brooklyn, Chairman of the Committee on Medical Economics of The Medical Society of the State of New York; and Dr. Seth A. Brumm, President-Elect of the Philadelphia County Medical Society. Both speakers told of the methods and motives of the promoters in the wealthy "Foundations" which were conducting surveys and devising methods of giving medical service according to the methods of "Modern Business", through managers who knowing little of the practice of medicine would devise new methods based on statistical studies. Still, their studies have a popular appeal and will be likely to prevail in New Jersey unless the physicians of the state devise a better system. Fortunately, the Medical Society has already announced the "Public Health Hour" as its answer to the challenge to the medical profession, and the society is actively planning further extensions of medical service for those who otherwise could not pay for the services in the more expensive and extensive fields of specialism, and in the

ordinary fields of prevention at a time when the individual is unaware of future danger, and is disinclined to seek protection.

The burden of both addresses was that, while the participation of government officials and lay organizations may be necessary for the distribution of medical services, the practicing physicians of New Jersey can evolve methods which will be far more practical and efficient than those devised by the "Foundations".

The guest speakers were followed by Dr. Thomas K. Lewis, of Camden, Chairman of the Sub-Committee on Medical Practice of the Welfare Committee of the Medical Society of New Jersey. Dr. Lewis described the results of the surveys of dispensaries, hospitals, school medical services, and other forms of medical practice by impersonal methods at public expense; and presented a series of definite recommendations made by the committee as standards for conducting the public medical services. His paper was a demonstration of the possibility of carrying out the suggestions of the guest speakers that physicians can develop superior substitutes for the impersonal plans of the "Foundations".

PRESIDENT'S ADDRESS

The second general meeting was held on Wednesday noon to hear the annual address of the President, Dr. Frederic J. Quigley, which is printed on page 320 of this Journal. A practical feature of his address was his call to the officers of the American Medical Association to devise a definite plan by which the Medical Societies of the several states can coöperate in developing methods for the distribution of medical services which shall be superior to the proposed systems of sickness insurance and state medicine which are promoted by the rich "Foundations". What New Jersey has done for its component county societies, the American Medical Association can do for the Medical Societies of the several states.

The suggestions of Dr. Quigley were approved by the House of Delegates on Thursday, and the New Jersey Delegates were instructed to present the requests to the House of Delegates of the American Medical Association at its meeting on Monday, June 11, 1934.

INAUGURAL ADDRESS

The inaugural address of Dr. Lancelot Ely, who was about to become President at the close of the Annual Meeting, was delivered at the close of the last meeting of the House

of Delegates. Dr. Ely reviewed the major activities of the Society during the past year and stated his intention of carrying them on with the vigor and earnestness of his predecessor, Dr. Quigley. Dr. Ely's address appears on page 327 of this Journal.

SECTION MEETINGS

Twelve meetings of the scientific sections were held, at which thirty papers were presented; while ten papers were presented before the General Meetings of the whole society. These forty papers will be published in *The Journal* during the year, and will be the principal source of supply of material for the department of "Original Articles".

THE WOMAN'S AUXILIARY

Pleasing features of the Annual Meetings during the past six years have been the meetings of the Woman's Auxiliary of The Medical Society of New Jersey. The Auxiliary held its own series of meetings beginning with that of the Executive Board on Tuesday afternoon. The general session was held on Wednesday morning, with the President, Mrs. Harry V. Hubbard, of Plainfield, presiding. The annual reports of the officers and committees were read and discussed and officers were elected. The proceedings will be published in the Transactions of The Medical Society.

The general session was followed with a luncheon at which the physicians had been invited. The attendance was 150, the room being filled to its capacity.

Dr. Julius Levy, of Newark, Pediatric Consultant to the New Jersey State Board of Health, was the guest speaker during the luncheon. He presented the results of a survey of the immunization of children throughout the state by means of a house-to-house canvass made by workers supplied by the Civil Works Administration. Dr. Levy exhibited charts and graphs upon lantern slides showing the proportions of children of pre-school ages who were immunized against contagious diseases, especially diphtheria. The percentage varied from one in some of the rural communities to thirty in the larger centers, such as Newark.

Dr. Levy also showed that, while the number of diphtheria cases has been reduced to less than one-fourth that of ten years ago, yet the proportion of those who die is as high as ever, showing that the disease itself is still dangerous and that there is no diminution of its virulence as occurs with smallpox and scarlet fever. The address was well adapted

to promoting the interest of the women in popularizing the "Public Health Hour", in which physicians will give immunizations at special rates to those unable to pay the ordinary fee.

Mrs. Robert W. Tomlinson, of Wilmington, Delaware, President-Elect of the Woman's Auxiliary to the American Medical Association, was the guest of honor and spoke on the objects and aims of the Auxiliary.

PRESIDENT'S BANQUET AND BALL

The principal social event of the Annual Meeting was the President's Banquet and Ball held on the evening of Wednesday under the auspices of the Woman's Auxiliary. The attendance was so large that the banquet hall was filled to overflowing. Dr. William J. Carrington, of Atlantic City, Chairman of the Committee on Program and Arrangements, presided and presented the speakers in introductions familiar and humorous. President Quigley and President-Elect Ely gave brief greetings.

The guest speaker was Dr. James J. Walsh, Dean Emeritus of Fordham University, New York City, whose talk was highly entertaining and educational on the subject "Funny Things That Cure People". Dr. Walsh said that he would talk principally on electric cures, for electricity was the mysterious agent which came into use in about the year 1750 and produced immediate reactions which could actually be felt. The early cures were typical of the newer ones which cure everything for a few months and nothing at all after their novelty has worn off and their failures become known. Dr. Walsh said that he was once asked by a patient if he should take a new cure for consumption which was widely noticed in the daily press, and Dr. Walsh replied, "Yes, and do it quick while it still cures."

Dr. Walsh explained the reason for the efficiency of the cures for a few months, stating that chronic aches and tenderness are peculiarly susceptible to cure, for half of them are imaginary, and half of the rest have an imaginary element, while one quarter have a physical basis which of course is not affected by the treatment. When the failures in the cases of

the physical types become known, the fame of the cure always subsides quickly.

Dr. Walsh talked in a simple conversational style which was highly sensible as well as entertaining. Speaking of poultices, he described the fame of cranberries as poultices for inflammations because of their redness. When he started to practice medicine, the popular kind of poultice to use was soap and sugar for the back of the neck, and bread and milk for the face; and he told of a boy with a swollen jaw to whom he applied a bread and milk poultice to great relief of the boy and his mother, and the reputation of the doctor, until Dr. Walsh found that the patient had eaten the poultice.

Dr. Walsh's talk was ideal for the occasion, for it was given in a style that was homely and wholesome, as well as funny.

The banquet was followed with dancing, the floor being crowded for hours. The banquet and dance were highly successful and entertaining.

PUBLICITY

The Editor was appointed on a committee to meet the newspaper reporters and give them a synopsis of the daily events and addresses. The reporters represented the local newspapers, the Associated Press, the New York Times, and others. They were well informed and sought facts rather than sensationalism. They scrupulously observed the standards of courtesy and confidences, and gave the meeting an amount of space which its importance deserved. The articles should enhance the respect of the people for the medical profession and the practice of scientific medicine. This result is of such importance as to justify the careful preparation of abstracts and summaries of the addresses in advance of their delivery, so that they may be ready for the reporters at the Annual Meeting.

THE EXHIBITS

The exhibits constituted a valuable feature of the Annual Meeting. They were in three groups: 1, scientific; 2, art and hobby; and 3, commercial.

SCIENTIFIC EXHIBIT

An extensive scientific exhibit was brought together through the efforts of a committee consisting of: Dr. John W. Gray, chairman, Newark; Dr. George S. Reitter, Vice-Chairman, Orange; Dr. Harrison S. Martland, Newark; Dr. Asher Yaguda, Newark; Dr.

H. R. Casilli, Elizabeth; Dr. Robert A. Kilduffe, Ventnor; Dr. Wallace W. Mavor.

The Medical Society provided the shelves and display racks which will be kept for use year after year, being stored free by the Atlantic City Hospital. Some of the exhibits

were of such interest and value that they will be shown at the American Medical Association meeting in Cleveland during the week beginning June eleventh.

The list of the exhibitors and the subjects of their exhibits were as follows:

1. Tuberculosis — pathological specimens. M. I. Marshak, W. Freeman and W. Antropal, Bayonne Hospital, Bayonne.

Sections of lungs and charts of the pathological features.

2. Breast cancers. A. R. Casilli, Elizabeth General Hospital and the St. Elizabeth Hospital, Elizabeth.

Pathological specimens, also charts and explanations.

3. Cardiac Lesions. Essex County Heart Committee. S. A. Goldberg.

Specimens and photomicrographs.

4. Generalized Melanomatosis from a pigmented nevus, showing disseminated pigment spots in all the organs of the body. S. A. Goldberg, Pathologist to the Presbyterian Hospital, Newark.

Also a series of cystic tumors of ovary, both solid and cystic. A whole series beginning with benign and ending with malignant. About 100 cases. Specimens, charts and photomicrographs.

5. Henry B. Orton, Presbyterian Hospital, Newark, and the Eye and Ear Infirmary.

Cancer of Larynx. An extensive series of plaster casts, colored, showing dissections, and operations, and photographs of patients in good health years after their operations.

6. The death zone of asphyxia.

An extensive series of colored plaster models. Henry B. Orton.

From the office of Essex County Medical Examiner, Newark.

7. Orange Memorial Hospital, Orange. Arthur R. Abel and Ernest A. May.

General pathologic exhibit showing kidneys, stomachs, hearts, and livers.

8. Cancer. American Society for Control of Cancer, 1250 Sixth Avenue, New York City.

Charts, Wax models, and literature.

9. Tumor clinic in Paterson General Hospital. Leslie R. Taber.

Photographs and charts.

10. Urinary Tract Lithiasis. Clarence R. O'Crowley and Harrison S. Martland, City Hospital, Newark.

Charts and stones removed from the kidney.

11. Office of the Medical Examiner in the detection of crime. Harrison S. Martland, Newark.

Gall stones. Photographs of injuries and accidents.

12. Mountainside Hospital, Montclair, M. J. Fein. Over 50 gross specimens.

13. Regional tumors of the kidney, bladder and intestine. Specimens and photographs. A. M. Gnassi, Jersey City Hospital, Jersey City.

14. Tumors of Bone. Milton Friedman, Beth Israel Hospital, Newark.

15. Includes a case of Adamantinoma of tibia, which is exceedingly rare in the tibia. It usually comes in the jaw from a tooth germ. It does not metastasize but recurs if it is not completely extirpated.

16. Brain tumors. Thomas S. P. Fitch, Muhlenberg Hospital, Plainfield, and Somerset Hospital, Somerville. Edgar Holden and John W. Gray Hospital and Home for Crippled Children, Newark.

Photographs and specimens and charts.

17. Unusual heart tumors. John W. Gray, and Edward Fendrick, Newark.

Charts, specimens and photomicrographs.

18. New Method of Cardiac measurement. M. Rona, New Brunswick, and W. G. Herrman, Asbury Park.

X-ray photographs showing the methods of measuring the size of the heart.

19. Roentgenological diagnosis of lesions of the esophagus. F. Baker and W. J. Marquis, Newark.

Diverticula, strictures, and other lesions.

20. Giant cell tumor of scapula, E. Reissman, Memorial Hospital, Newark.

Non-malignant condition simulating a metastasis in lung.

21. Changes in the urinary tract in pregnancy. Harry J. Perlberg and Irving J. Strumpf. Margaret Hague Maternity Hospital, Jersey City.

22. X-rays of unusual spinal conditions. George S. Reitter, Memorial Hospital, Orange.

23. Suppurative hips in children. G. Herbert Taylor, East Orange.

X-rays taken before and after operation.

24. Urinary tract lesions. William Wallace Maver, Christ Hospital, and St. Francis Hospital, Jersey City.

25. Industrial x-rays. W. H. Kellogg Co., Jersey City, and DuPont Film Manufacturing Corp., Parlin.

Showing welds, perfect, porous and defective, in heavy bars of steel.

26. Intra-cranial pathology. C. W. Schwartz, Neurological Institute, New York City.

27. Sick cell anemia. H. A. Vogel, General Hospital, Elizabeth.

Porosities of bone.

28. Main nerve trunks in brain stem. R. D. Swain, Eye and Ear Infirmary, Newark.

Charts and specimens on which colored threads were superimposed to show the tracts.

29. Bacteriology and pathology of rheumatoid arthritis. Reginald Burbank, French Hospital, New York City.

Charts and photographs.

30. Studies in human capillaries in the peripheral circulation. Joseph Weiner, Monmouth Memorial Hospital, Long Branch.

Photographs of capillary loops in the nail beds of the fingers. Diagnosis of early vascular changes in arteriosclerosis, Raynaud's disease, and diabetes.

31. Diagnosis of amebiasis. The Proctoscopic method. Manfred Kraemer and Maurice Asher, Newark.

The smear method of diagnosis. Pictures and colored drawings of rectal lesions, and microphotographs of the amebas.

32. Blood dyscrasias. Asher Yaguda and Richard Wadsworth, Beth Israel Hospital, Newark.

Blood photomicrographs by color photography.

33. Endocrine disturbances in women. Asher Yaguda and Rita Finkler, Beth Israel Hospital, Newark.

Photomicrographs, also plaster casts of white mice showing the effects of prolane on the ovaries.

34. Plastic surgery. Lyndon A. Peer, Eye and Ear Infirmary, and City Hospital, Newark.

Photographs before and after operations.

35. Medical aspects of chronic sinusitis. Relation of the maxillary antrum to some general symptoms. George H. Lathrope, Royce Paddock, Lee W. Hughes and Lyndon A. Peer.

Charts and drawings.

36. Synopsis of course and treatment of rheumatoid arthritis. John W. Gray, Newark.

Autopsy evidences in three cases. Photos and photomicrographs; also a treatment chart.

37. Pathological specimens. William Antopal and S. J. Penchausky, Bayonne Hospital.

38. Hodgkin's disease of the lung, comparative sendiasin lymphosarcoma, actinomyces and tuberculosis. Sylvan E. Moollen, St. Peter's Hospital, New Brunswick.

39. Osteome tumors. John D. Tidaback, Summit.

40. Unusual cases shown by x-ray. W. G. Herrman, Asbury Park.

41. Compression therapy of the lung. Samuel B. English, Glen Gardner.

THE ART AND HOBBY EXHIBIT

The Medical Society conducted an *Art and Hobby Exhibit* of work done by physician members or the immediate members of their families. The committee in charge of the exhibits consisted of: Dr. William K. Campbell, Chairman, Long Branch; Mrs. A. H. Lippincott, Camden; Mrs. R. A. Shirrefs, Elizabeth; Mrs. Norton A. Wilson, Elizabeth; Mrs. H. V. Hubbard, Plainfield; Dr. H. B. Orton, Newark; Dr. Salmon S. Bauch, Dr. M. J. Kaufman, Newark; Dr. C. D. Martinetti, Orange; Dr. Lancelot Ely, Somerville; Dr. F. G. Hughes, Plainfield; Dr. H. F. Johnson, Plainfield; Dr. Milton A. Shangle, Elizabeth; Dr. C. C. Beling, Newark; Dr. Emery Bokar, Newark.

There were twenty-one participants whose names and contributions were as follows:—

1. Dr. J. Corwin Mabey, Montclair, 8 photographs, enlargements on various subjects.

2. Dr. W. L. Vroom, Ridgewood, 3 photographs, enlargements of buildings and wild buffalo.

3. Dr. W. C. Wescott, Atlantic City, 2 photographs, Egyptian and local scenes.

4. Dr. L. H. Loeser, Newark, 3 photographs, outdoor scenes.

5. Dr. F. J. Hughes, Plainfield, 1 framed oil painting.

6. Miss Carolyn Teimer, Newark, 4 framed oil paintings.

7. Miss Elizabeth Spencer, Woodbridge, 1 framed oil painting and a plaque.

8. Mrs. Dorothy Maver, Jersey City, 3 framed oil paintings.

9. Dr. H. L. Lockwood, Jersey City, 3 framed oil paintings.

10. Dr. S. Husserl, Newark, 4 busts, including the bronze bust of Dr. Ill (see page 362).

11. Dr. M. J. Kauffman, Newark, 14 figurines, made from Russian bread; and 3 painted plates.

12. Mrs. Stanley Nichols, Long Branch, 1 beaded handbag 100 years old.

13. Dr. C. Garrabrant, Atlantic City, 1 photograph of Jonathan Pitney, founder of Atlantic City; a hymn book, a bible, and a surgeon's scarifier.

14. Miss Mary Lee Davis, Haddonfield, a child's bust, a Japanese face mask, a bracelet, ring, head band, and pin in silver work.

15. Dr. Lancelot Ely, Somerville, 15 small stone images from a pre-historic mound.

16. Mrs. Walter B. Mount, Montclair, collection of book plates.

17. Dr. Emery Bokor, Newark, 3 posters entitled "Our escape-neuroses in fine arts", used as an introductory sign-panel at the entrance to the exhibit.

18. Mrs. A. C. Wallin, Matawan, collection Bavarian china.

19. Dr. William Campbell, Long Branch, color photographs of outdoor scenes.

20. Dr. Leland S. Madden, Pleasantville, portable desk top, adjustable for reading, patented by Dr. Madden.

21. Mrs. H. Corbusier, Plainfield, Indian pottery and blankets; also Katinchas or ceremonial dolls.

COMMERCIAL EXHIBIT

Twenty-one manufacturers and dealers in medical and surgical wares took booths in the registration room and hallway, and composed a noteworthy commercial exhibit. The location was favorable, for all the members passed by the exhibits in going to the main assembly room. The exhibitors expressed themselves as pleased with the attitude of the physicians. The list of exhibits and the representatives was as follows:

Cameron Surgical Specialty Co., 1874 Broadway, New York City, Mr. Walter F. Smith, electro diagnostic instruments and Cameron cauterodyne, all boilable and sterilizable, including the light bulbs.

Walker-Gordon Laboratory Company, Inc., Plainboro, N. J., Mr. Henry Jeffers, Jr. Certified and acidopholus milk. Moving pictures of the cows and the "Rotolactor" or mechanical milker in action.

The Ferment Co., 640 West 215th Street, New York City, Mr. Joseph C. Richard, Acidopholus and bulgaricus cultures, whey cultures, etc.

Holland-Rantos Company, Inc., 31 East 18th Street, New York City, Miss Anne Kennedy, Gynecological specialties.

E. R. Squibb & Son Co., Squibb Building, New York City, Mr. F. F. Fletcher, Drugs and chemicals, including liver concentrates, and sex gland products and hormones.

Gerber Products (Fremont Canning Co.), Fremont, Michigan, Mr. William T. Devine, Strained vegetables for baby feeding.

Horlick's Malted Milk Corporation, Racine, Wisconsin, and 3572 DeKalb Avenue, Bronx Borough, New York, Mr. T. O. Kurtzner, Malted milk and its preparations.

Kalak Water Co., 6 Church Street, New York City, Mr. T. H. Janes. A carbonated, alkaline water.

United States Fidelity & Guaranty Company, 31 Clinton Street, Newark, Schryver and Geyler, Managers, Official agents for writing malpractice insurance for members of The Medical Society of New Jersey.

Petrolagar Laboratories, Inc., Chicago, Illinois, Mr. E. M. Serota, Perborate powder for use as a mouth wash and as a tooth powder.

Standard Reagents Co., 4523 York Road, Philadelphia, Pa., Dr. William B. Kohn, Laboratory specialties and supplies. Reagents and apparatus for making micro determinations of blood sugar.

Lea & Febiger, 600 Washington Square, Philadelphia, Pa., Mr. Philip Gotz, Medical publications, "Diseases of the Skin", Ormsby, "Obstetric Medicine", Adam and Slen-glitz; "Hypertension and Nephritis", Fishberg.

C. V. Mosby Co., St. Louis, Missouri, Mr. L. R. Wilson, Medical publications. "Fractures, Dislocations and Sprains", Key and Conwell.

The Geo. P. Pilling & Son. Co., Philadelphia, Pa., Mr. Henry Pilling, Surgical instruments and hospital supplies. Bronchoscopic instruments of the Chevalier Jackson model. Stainless steel wire for sutures.

Coward Shoe Co., 20 West 34th Street, New York City, Mr. C. C. Lippincott, Orthopedic shoes in current styles for prevention and correction of defects.

A. S. Aloe Co., 1819 Olive Street, St. Louis, Missouri, Surgical instruments and physiotherapy equipment.

Charles Lentz & Sons, 33 South 7th Street, Philadelphia, Pa., Mr. Charles Lentz, 3rd. Stainless surgical instruments of noco steel, hand forged.

Complex Oscillator Corp., New York City, Complex-oscillators.

Way Agency, Inc., Newark, N. J., Automobile insurance.

The Mennen Co., 345 Central Avenue, Newark, N. J., Mr. F. S. Dietrich, baby oil and talcum powders.

E. and W. Blanksteen, Managers, 76 Montgomery Street, Jersey City, Medical Society of New Jersey, Group, Accident, and Sickness Insurance.

HONOR TO DR. EDWARD J. ILL

THE RECORD OF A MEETING OF THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY ON MAY 17, 1934, IN NEWARK

It is an important contribution to the practice of medicine that four hundred physicians in the City of Newark should spend an evening in contemplation of the character and work of their beloved colleague, Dr. Edward J. Ill, on the eightieth anniversary of his birthday. Sixty years in the practice of his profession and the discharge of his civic duties have given him an inexhaustible store of experience upon which he still continues to draw with the keen comprehension, kindly judgment, and unselfish devotion which have characterized him through long years of activity and usefulness. In fact, Dr. Ill has attained to the distinction which is the ideal of every conscientious physician.

History is mainly biography, and its events are personified in the lives of a few outstanding leaders. Dr. Ill might truthfully say with Milton in describing the stirring events of his day, "All of which I saw, and much of which I was." In devoting the evening of May 17th to an appreciation of Dr. Ill, the Academy of Medicine of Northern New Jersey also preserves a record of a half century of medical progress to which Dr. Ill was a conspicuous contributor.

Dr. John F. Hagerty, Past President of the Academy, and of The Medical Society of New Jersey, presided and opened the meeting with the following address on "Dr. Edward J. Ill, the Friend of the Academy":

INTRODUCTORY ADDRESS

By JOHN F. HAGERTY, M.D., Newark, N. J.

Mr. President, Dr. Ill, Honored Guests, Fellow-members of the Academy and Friends: I am happy to see such a large gathering here because I know that you have been prompted to come by the same motive that animated our Academy in arranging this meeting—to do honor to one of the oldest and best known and most highly esteemed members of the medical profession in our city, and county, and state.

This Academy was started upon its career twenty-four years ago—and has been the object of watchful care and interest of Dr. Ill ever since. It has also been the recipient of his generosity from time to time until now it possesses one of the finest collections of books and prints illustrating the history of medicine and surgery to be found anywhere. We honor ourselves in honoring one who has done so much for us, and who, by his long and useful and exemplary life, has shed such lustre and distinction upon the profession to which we have the honor to belong.

It is a wonderful experience to have lived

four score years and find one's self in almost perfect mental and physical vigor. It is a remarkable privilege to have practiced medicine almost sixty years, during a time which has been declared by many to have been the most remarkable period in the history of the world. He has witnessed the astounding progress that has been made in the arts and sciences during that time—not the least wonderful and beneficent of which has been the transition of medicine and surgery from an empirical, unscientific calling to a scientific, rational, and progressive art which has brought incalculable benefits to mankind. "The last seventy years," said Osler, "has witnessed greater progress in medicine and surgery than the two thousand years which preceded them."

And what a joy and satisfaction not only to have seen these wondrous changes, but to have been an active participant in the work and a worthy exponent of the progressive methods and practices which have identified and glorified medicine and surgery during recent years. Dr. Ill's outstanding abilities as

a surgeon and gynecologist will be portrayed by distinguished physicians who, because of their respect and admiration for him and for his work, gladly consented to come here and speak. But it is fitting and proper that we, who have known him so long and so well, should emphasize the value of his example and his influence among us.

There are many factors which have a determining influence upon institutions and the members of which they are composed, but one of the most helpful influences for good is that of a well-spent life, which has been splendidly exemplified in the career of Dr. Ill. He has shown us the value of having an ideal and of adhering to it. To adopt for his life work a worthy calling like medicine, to have persevered in its study and mastery, to have resisted the allurements of other more attractive and more remunerative work, and to have acquired over the long years a reputation not only for efficiency but for sterling honesty and integrity, represents a life of inestimable value in its influence upon his colleagues and co-workers, and merits the highest recognition by those who shine in its reflected glory.

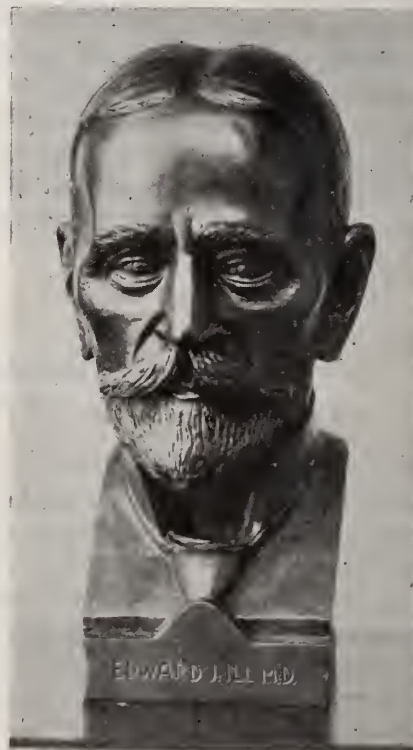
This Academy of Medicine does well to show its appreciation of his splendid example and deeds, and your Chairman, who has been associated with him in many ways over a long period of years, considers the privilege of presiding at this meeting a very signal honor. It was a happy thought of our President to have initiated those well deserved exercises; and the Committee has felt that no better means of recognizing Dr. Ill's devotion and services to the Academy could be found than by preserving his features in bronze.

THE BRONZE MEMORIAL

Very happily one of our own members, Dr. Siegfried Husserl, in addition to his ability as a physician, has found time to cultivate the art of Sculpture as an avocation. He has made a bronze bust of our honored Fellow, which is highly creditable to his skill and pleasing to all who have seen it, and which will serve, for all time, to identify Dr. Ill with the Academy

which he loves so well. The expenses incurred in casting this beautiful memorial have been met by the voluntary contributions of members of the Academy and some lay friends who requested permission to contribute. I wish it were possible to convey to Dr. Ill the many kindly expressions received from the members with their contributions.

Mr. President, I am going to ask Dr. Husserl, to whom we are indebted for this beautiful bust, to unveil it.



The bronze bust of Dr. Edward J. Ill, made by Dr. Siegfried Husserl, Newark, N. J.

(Dr. Husserl unveiled the bust with a brief word in appreciation of the opportunity to make a contribution to a permanent memorial to his friend, Dr. Ill.)

And now, Mr. President, I ask you to accept this memorial on behalf of the Academy with the cordial expression of esteem and good-will of the members, and the sincerest wishes to Dr. Ill for his continued good health and happiness for many years to come.

Acceptance of the Memorial

Dr. Arthur W. Bingham, President of the Academy, accepted the bust with a few words, "in honor of one who has spent his life in advancing the science of medicine, and the good of his fellow men".

Felicitations from the Essex County Medical Society

Dr. Edward W. Sprague, President of the Medical Society of the County of Essex, brought the felicitations of the members of Dr. Ill's home society. "To be eighty years young," he said to Dr. Ill, "is better than forty years old. Your years have been full of usefulness. They have brought comfort and

relief to thousands of sufferers, and inspiration to your fellow workers."

Greetings from the Medical Society of New Jersey

Dr. Frederic J. Quigley, President of The Medical Society of New Jersey, brought the greetings of the physicians of the State to their senior Past President, who still gives essential service to the Society as an active member of the Publication Committee, and the promotor and conservator of high class medical literature and records.

The guest speakers were Dr. George W. Kosmak and Dr. George Gray Ward, both of New York City. The meeting closed with a happy response by Dr. Ill.

DR. EDWARD J. ILL, THE PROGRESSIVE GYNECOLOGIST

By GEORGE W. KOSMAK, A.B., M.D.,

Editor, American Journal of Obstetrics and Gynecology

An address before the Academy of Medicine of Northern New Jersey in Newark, May 17, 1934

It is not only a privilege but an honor to be present on this gala occasion when a host of colleagues and friends of Dr. Ill is bearing witness to his eminence as a physician, a teacher, a clinician, and a useful citizen. All of these well-wishers are agreed with the praise which has been lavished upon him by the speakers of the evening. No one can gainsay the fact that he merits the encomiums, and many more. His has been a noble career, characterized by an unfailing industry and a close devotion to his chosen profession. A man is measured by his works, but the man himself may be a measure of what has transpired during a long and eventful life. It is during Dr. Ill's lifetime that medicine has scored great advances; at first in discoveries, then in technique, and now it is undergoing another change, largely social, and too subtle in many respects for judgment to be passed upon at this time.

It is of interest to take note of the great happenings in medicine of the latter part of the nineteenth century and the beginning of

the twentieth; for it is during this period that gynecology was born—a field in which Dr. Ill was a distinguished pioneer. Dr. Ill himself should be the best commentator of what has occurred because he has lived through those changes and has been a witness of the expansion of the specialty from very limited mechanistic procedures of those earlier days to that development in which physiology, bacteriology and pathology have taken so prominent a part. The limitations of early gynecology were well marked. The specialty then dealt largely with the repair of lesions due to the accidents and complications of labor; and it is only when these were conquered by the remarkable dexterity of Simms and his followers that the search developed for other worlds to conquer. It is true that McDowell, a century ago, removed an ovarian tumor by laparotomy, but it was many years later that gynecologic surgery accomplished its outstanding accomplishments in hysterectomy for fibroids and cancer.

And then there came the recognition of the power of Roentgen rays and radium with which we are now displacing to a large degree

certain of the purely surgical procedures of the past. The gynecologist eagerly seized upon these new agents and added them to his armamentarium. Their application has become less empirical than in the earlier days, their possibilities and limitations are becoming better recognized because the physicist has been called in to establish dosage and thus to make the use of these agents more satisfactory and safer. It is to be hoped that within the next decade or two we may know even more about the actual workings of these mysterious agents of which we practitioners of the present day know only largely the effects.

And now gynecology is entering another field, which is still speculative in many respects, namely that of endocrinology. Here again empiricism reigned until the underlying physiologic facts of these essential organs were more definitely brought into the light. We are no longer satisfied with the various glandular extracts and solutions of only a few years ago, but are attempting to do with the active principles of organs reduced to a chemical basis what we failed to accomplish with the cruder preparations of the past.

With the development of gynecology must be linked that of obstetrics. The earlier gynecologists were satisfied to repair the damage which the obstetrician had done. I have said before, his field was limited, but later he found that there were other fields of endeavor besides the repair of obstetric damage. This required a closer alliance between these sister specialties, and we find a practical union of the two more frequent and evident today than thirty or forty years ago. Obstetrics, like gynecology, must concern itself not only with the treatment of abnormalities, but also with their prevention; and as the gynecologist *per se* has sought to study the prevention of cancer, so the obstetrician seeks to prevent the development of toxemia and other conditions which affect the safety of childbearing.

Woman today in her sexual and generative functions is regarded in a different light than formerly. Childbearing has become a matter of concern not only to the doctor and the prospective mother, but to the entire community. Witness the interest shown in recent years by

lay groups of all kinds in addition to those of a strictly medical character. We might also say that the interest of the mother and her unborn child is the interest of the community; for it is essential for the welfare of the latter that childbirth be deprived of its possible complications. A healthy mother with healthy children is one of the most desired assets of the nation.

Dr. Ill has lived through a period in which the world has undergone greater changes than for centuries past. He has been a witness to these various happenings, and a witness not on the sidelines but in the midst of the conflict, taking an active part in its development and working in the army at first as a private and finally as a general—an army for the conquest of disease and for the welfare of woman-kind. He has seen medicine as the expression of the most advanced individualism. Perhaps the next half century will witness a reversal of this conception of medical practice; and the individual doctor may disappear from the scene and his place be taken by a government employee acting as a mere cog in the social machinery. Whether this change will come about, the coming few years probably will decide. Whether that close relation between physician and patient, which was characteristic of the age in which Dr. Ill was active, will be supplanted by one in which people are to be treated *en masse*, is a question yet to be solved. Those of us in the present generation who regard the practice of medicine as more than a mechanistic procedure may find it difficult to adjust ourselves to this new view. The decision is in the lap of the gods, and we can only hope that the results will be to the best interests of those people whom we of an older generation have tried to serve as friends and counsellors as well as doctors.

It seems to me that Dr. Ill will ever serve as an example of that group of noble and conscientious physicians whose interests were devoted entirely to the welfare of their patients and the good of the community. He may rest assured that his life work has endeared him to his colleagues, who show their recognition of his sterling worth and character by the tribute which they are paying him this evening.

EDWARD J. ILL, THE VERSATILE MAN

By GEORGE GRAY WARD, M.D., F.A.C.S.

Chief Surgeon of the Woman's Hospital, New York City, and Professor of Obstetrics and Gynecology Emeritus, Cornell University

An address before the Academy of Medicine of Northern New Jersey at Newark, May 17, 1934

It is a great pleasure and a very special privilege to be asked to pay a tribute to our distinguished friend and honored guest, Edward J. Ill, on his eightieth anniversary, and I thank your committee for this opportunity and the honor.

Born in 1854 and graduated in Medicine in 1875, he has lived to experience sixty years of the evolution of medical and surgical science. It is not necessary for me to enumerate to you, who know him so well, the many honorable positions on various hospital staffs and in medical societies that he has held. Suffice it to say that in addition to his attainments in gynecology, obstetrics and abdominal surgery, he was one of the Founders of the American Association of Obstetricians and Gynecologists, and in 1898 was elected its presiding officer.

He also was elected a member of the Board of Education, and largely through his efforts succeeded in making contagious diseases reportable. He has served for fourteen years as a Trustee of the Newark City Home for Incurable Children. In 1908 the Chancellor of the State of New Jersey appointed him a Director in the Prudential Insurance Company to represent the policy holders, which position he holds today.

He has been foremost in the campaign against cancer and is Chairman of the Committee of the American Society for the Control of Cancer in the State of New Jersey.

These few instances but serve to show how varied have been his interests. His fame rests not only in his accomplishments in his chosen specialty, but he has always taken a keen and active part in all that pertains to the public welfare of your community. He is rightfully considered the Dean of the medical profession in New Jersey.

Dr. Ill from the beginning of his career was not content to practice merely to earn a living, but he has always continued to study and keep abreast of the developments in medicine and

especially in that department of surgery for which he is known throughout the land. He was one of the pioneer specialists in New Jersey, but his specialization was founded on a broad experience in general practice. He has never been a narrow specialist but has always followed the admonition of Plato in the *Charmides* that the whole must be studied also, "for the part can never be well unless the whole is well."

It is interesting to pause a moment and consider the many changes and marvelous developments in the art and science of surgery that Dr. Ill has witnessed throughout his sixty years of active practice as a gynecologist and obstetrician. Dr. Ill began to practice gynecology in the days of the "irritable uterus", "cellulitis", "ovaritis", and "haematocoele", and when nearly all hysterical and neurasthenic manifestations were supposed to originate in the uterus.

Pessaries galore of every shape and variety constituted an important part of the gynecologist's armamentarium for the cure of every degree of uterine displacement, and great reputations were built on the invention of these many curious props for the support of these relaxed and languid parts. The medical student of that day had a difficult task to memorize the many varieties of pessaries and theories upon which they were supposed to function. Out of them all, however, a very few, which were founded on correct principles, have survived to render valuable service in suitable cases.

These were the days when much importance was attached to the local treatment of "ulcers of the neck of the womb" by painting the vaginal vault and cervix with Churchill's tincture of iodine, or the use of the solid stick of silver nitrate to canterize the ulcers. Early diagnosis of cancer of the cervix was rarely made. Dilatation with sponge tents and intra-uterine applications of iodine and carbolic acid for so-called "endometritis" were much in

vogue. Repositing a retroverted uterus with an intrauterine sound, which worked with an intricate mechanism and frequently caused serious trauma and subsequent infection, was quite the thing.

During this period asepsis was not understood. Antisepsis was the practice, copious washings with bichloride solutions, the operation done under the carbolic spray, bare hands and arms, no masks or coverings for the head, or drapings for the patient were employed. Then the ability of the surgeon was judged by his speed in operating. The greater the speed and dexterity, the greater the surgeon, often to the undoing of the patient.

Fibroids were taboo so far as abdominal surgery was concerned, for fear of opening the abdominal cavity, the mortality was so high. If one were bold enough to attempt it, the amputated stump of the cervix was caught in a clamp and cauterized with a hot iron and brought outside the abdominal incision to heal. The approved method was to shrink the fibroid with the galvanic current, introduced in 1884 by Apostoli of France. It was not until 1889 when Stimson taught us to ligate the uterine and ovarian arteries separately that hysterectomy began to come into its own. Myomectomy as we do it today was unknown.

Glass drainage tubes were considered essential in all abdominal operations to safeguard the patient from infection.

Foeticide by electricity was the correct procedure in ectopic pregnancy.

Removal of the normal ovaries for dysmenorrhea—Battey's operation—devised in 1872, was the fashion. I have in my collection at the Woman's Hospital a photograph of Battey's first patient, given me by Howard Kelly. He met the lady in 1921 when he was in Rome, Georgia, to deliver an address at the unveiling of Battey's monument.

Just prior to 1880, at the time when Dr. Ill was beginning practice, there was a great awakening of interest in gynecology in this country, due to the appearance of several outstanding books on the subject. T. Gaillard Thomas in 1868, Emmet's book in 1879, Skene's work on the female bladder in 1878, and later his textbook in 1889, Peaslee in 1872,

Goodell in 1879, and many others, all stimulated interest and focused attention on this great and unexplored field. The increase in gynecic knowledge during the following fifty years has been so vast and so rapid as to be astounding. Led by Howard Kelly, the host of textbooks with the development of medical illustrating which continue to appear have placed America's contributions to our specialty in a foremost position throughout the world. All this Dr. Ill has seen and lived to utilize in his daily work.

For instance, the great advances in bacteriology, such as Neisser's discovery of the gonococcus in 1879, Koch's discovery of the tubercle bacillus in 1882, the spirochete of syphilis in 1905 by Schaudinn, and Ehrlich's discovery of its cure by chemo-therapy; the change from antisepsis to asepsis in surgery; the x-ray as a diagnostic and therapeutic agent; the various laboratory tests, such as blood counts, blood chemistry, the sedimentation test, and the Wassermann test, the study of blood pressure; the discovery of radium and its marvelous action in malignant and non-malignant diseases in gynecology; insulin, making operations on diabetics safe; the diagnosis and treatment of sterility by the insufflation test of Rubin and the study of the male as a factor; Samson's discovery of endometriosis and the recognition of the trichomonas as a cause of leucorrhoea, are but a few of the many advances in knowledge relating to our specialty during this time.

Our entire conception of the processes by which the genitalia function has changed during this period. The new science of endocrinology with its wonderful possibilities was stimulated by Hitzman and Adler's recognition of the cyclic changes in the uterine mucosa in 1908. Then Halban and Knauer opened the way by their demonstration that the coördination of ovary and uterus is brought about by chemical substances, thus constituting the first step to the hormone theory. Stockard and Papanicolaou's discovery that cyclic changes in the vaginal mucosa occur and are dependent on ovarian function, and Allan and Doisy's establishment of the unit in quantitative hormone determination which forms the basis of the present hormone analysis, were further

steps, and finally, Aschheim and Zondek's discovery that the anterior lobe of the hypophysis is the motor of ovarian function, and that the pituitary hormone prolactin is excreted in large quantities in the urine of pregnant women, thus making possible the practical application of this discovery as a test for the determination of early pregnancy. As a result of this knowledge, the application of hormone therapy to disturbances of the menstrual function, while at present largely experimental, gives great promise of success.

In the domain of operative technic in gynecology and obstetrics, the advances have also been remarkable. The improvement in anesthesia, and the use of barbiturates as aids, the discovery of cocaine and its derivatives making possible local and spinal anesthesia; the use of rubber gloves and masks and the protection of the operating field; the greatly improved facilities in operating theaters, sterilizing plants and instruments; the development of cystoscopy, and the x-ray study of the urinary tract; electro-surgery with its radio-knife; blood transfusion; intravenous therapy; pituitary gland extracts; adrenalin and ephedrine, all these adjuncts which we use in our daily operative work were unknown when Dr. Ill began his career.

At that time, operative gynecology was very limited in scope and consisted mostly of plastic repairs of obstetrical injuries and minor vaginal surgery. To mention some of the advances, we note improvements in the technic for vesicovaginal fistula operations, the Wertheim and Schauta operations for cervical carcinoma, myomectomy and hysterectomy, conservation of ovarian tissue, newer cervical operations, modern plastic operations for systocele, rectocele, and prolapse and pelvic floor injuries, the various operations for a retro-displaced uterus, the operations for sterility, implantation of the ureters, the formation of an artificial vagina, the low flap cesarian section and the recent operation of presacral sympathectomy for pain. These are but a few of the many operative procedures that we have available today that were unknown sixty years ago.

What a great change has taken place in our

hospital care and nursing of our patients! The days of preoperative purging and drastic depletion are over, and the post-operative care has been greatly simplified and is more humane. Not the least of the changes which has meant much to the patient and also to the doctor has been the hospital standardization instituted by the American College of Surgeons. The requirement of adequate facilities and proper worthwhile records and audit has made the American hospitals of today vastly different places for the care of the sick than they were half a century ago. Then those who could afford it were operated upon in their homes. Today the hospital is so much safer and more convenient that the patient enters it as a matter of course for an operation or a delivery.

What a pleasure and privilege it must be to Dr. Ill to have seen all this amazing development in gynecological and abdominal surgery, and to have been able to utilize this knowledge for the benefit of his patients! To quote a statement of his made some years ago—"With a background of the old we must keep abreast of the new and make full use of every discovery as it comes." How well he has lived up to this precept we all know. During his career, Dr. Ill has made many contributions to scientific literature, the first in 1883 when he published a report of two cases in which he had resected and anastomosed the intestine—a rare operation in those days. He was then not thirty years old. A long list of papers have followed covering nearly every phase of gynecology, obstetrics and abdominal surgery. As a lover and collector of incunabula and rare medical books he is well known to you all, and his generous gifts of these treasures to your Academy of Medicine will ever keep his memory green to those who come after.

Now as we look upon his professional attainments and honors and appreciate his vast experience, we are led to inquire what has been the secret of his great success, not only his accomplishments in his professional work, but in having attained the love and respect of the entire community in which he lives? I think the answer is his personality. As Howard W. Haggard has well said, "As long as

human beings remain human beings, not only art as well as science, but the contact of personality must remain an integral part of the practice of medicine. When we are in pain we do not turn to the research worker but to the physician—the man.”

Dr. Ill exemplifies this, and thus his patients have sought him for the personal contact which throughout his many years of active service to the community he has given so generously, and which has made him so beloved. Like Machaon, the great surgeon of Homer's Iliad—

“A wise physician skill'd our wounds to heal
Is more than armies to the public weal.”

In these days of standardization and the trend toward group practice of medicine we are in danger of losing the personal and human relationship that should exist, and did exist in the medical practitioners of an earlier era, between the ailing men and women who turn to us for help. That relationship which breeds kindness and sympathy in the doctor and faith, confidence and hope in the patient is as essential as a scientific knowledge of laboratory tests in the practice of our art. It is, I fear, lacking in many of the younger generation of practitioners. Dr. Ill is a splendid example of what I wish to convey as throughout his long career of active work he has been

not only the wise and able physician, but the true, sympathetic friend and councilor of his many and devoted patients. As on another occasion he has said, “What greater reward can we have than to be useful to our fellow creatures and to have and to hold the esteem of our fellow practitioners.” Certainly he has that reward.

Now on behalf of the gynecologists and obstetricians of New York, I wish him a continuation of his happiness, health and usefulness for many years to come, and may I conclude by quoting an epigram from a favorite poet of mine, Alexander Pope, the sage of Twickenham, who wrote in his inimitable style on the occasion of another eightieth birthday—

“At length, my Friend (while Time, with still career,
Wafts on his gentle wing his eightieth year),
Sees his past days safe out of Fortune's power,
Nor dreads approaching Fate's uncertain hour;
Reviews his life, and in the strict survey,
Finds not one moment he could wish away,
Pleased with the series of each happy day.
Such, such a man extends his life's short space,
And from the goal again renews the race;
For he lives twice, who can at once employ
The present well, and ev'n the past enjoy.”

THE FUNCTION OF THE ACADEMY OF MEDICINE

By EDWARD J. ILL, M.D., Newark, N. J.

The closing address of Dr. Edward J. Ill in response to the felicitations of his colleagues in the Medical Profession at a meeting of the Academy of Medicine of Northern New Jersey in Newark, May 17, 1934.

Mr. President, Ladies, Fellows, and Guests:
Words fail me to express the joy of this evening. Your kind thoughts and remarks assure me of your trust and good fellowship. Looking back these many wonderful years, I hope my effort has been for good, and I trust it has been honest.

I am really embarrassed as to know what to say. To think that such learned and beloved men as my friends Drs. Ward and Kosmak should help us celebrate this occasion

touches me deeply. I feel much flattered by the presence of the Presidents of the state and county societies, and that such great physicians as I recognize among you should do me the honor of their attendance. I want to thank Dr. Husserl for the artistic work which he presented to the Academy, and lastly, I want to thank you all for this kindness to me. I trust that your goodness will not make me conceited for I well know “how much there is to do, and how little done”.

Because I have endeavored to do my duty in the past to this our beloved Academy is surely no reason for such appreciation on your part. If I have done anything worth while, it has been my endeavor to assist in raising the standard of knowledge in our medical men, and enhance their love for this our beloved profession. Our Academy has done all this, and has also brought us together in a more harmonious whole, exchanging mutual experience and knowledge.

The people of this community are also benefited by such an institution as this because they are getting better medical attention. I might go back and tell you of all the things that have made this institution such a glorious one. It is difficult for one of my age not to be reminiscent. A good writer told us that when men get old they are looking backward. I should rather love to look forward and say how much will be expected of the Academy of the future. Rabbi Ben Ezra says, "The last is yet to be,—the last of life for which the first was made."

It is the young men that I am particularly interested in, for the brain and sinew that comes with them. I know that our council is making it easy for them to come in with us; to take advantage of what we have to offer; to listen to our papers and discuss them. In other words, let them feel that they are one of us. This is entirely different from what the relation must be if the decorum is to be maintained in the hospitals. Then, there must be a supervisor and an underling, the supervisor being responsible for the service to the Board of Trustees as the assistant must be responsible to his supervisor.

I should like to know that the Academy will ever be a school for advancing the knowledge of our beloved profession, and also to produce a standard of ethics. I should like to know that it will raise the works and aims of the profession in the estimation of the whole people. I should like to feel that it will be the place for those who are interested in the book knowledge of the present day, and the glorious history of the past. To think of the old

masters and revere them is only our duty. I should like to think of the increase of the Academy in such a way that other scientific bodies would make it their home, for there is much to learn from the other sciences. We would have gained little except for them. Galen already said that "The physician is a handmaid to nature", and Rotitansky, the great pathologist, tells us, "It is the pride of medicine that it has come from the natural sciences, and in itself is a natural science."

There is one great satisfaction in having lived such a long life in one's profession at this time. Never has so much been accomplished in the same number of years as there has been in the sixty-two years that I have been in medicine. Think of the great improvements in medical education. When I once said to Dr. Walsh, "What became of you in the second year of our medical college?", he promptly answered that there was nothing more to be learned in the school—and it was true. Think of the young man of today with his wonderful foundation for efficient work. Think of the great chieftains in medicine during these sixty-two years. Think of such names as Sims, Scanzoni, Billroth, Kocher, Recklinghausen, Conheim, Robert Koch, Neisser, Ehrlich, Spencer Wells, Rudolf Matas, the Mayos, Crile, Ewing, and the great four of Johns Hopkins, Osler, Halstet, Welsh and Kelley, and you have a galaxy of only a few of those we ever have in our minds. Think of the advances in pathology and bacteriology; in aseptic surgery; in abdominal and brain surgery, and urology, and you have but a slight insight of the great things of which hardly anything was known before sixty years ago.

Whether we receive our knowledge from a Jew or a gentile, from an Asiatic or a Slav, makes no difference. When facts thus come to us are true, we are thankful for them. It is the eternal truth that our profession is after.

It is time that I close. Permit me to quote a writer of old philosophy who said, "Let this house be a shelter where troubled minds find peace and freedom from care, an hour of joy, and common brotherhood." I thank you.

County Society Reports

ATLANTIC COUNTY

Robert A. Kilduffe, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held in the Japanese Room of the Ambassador Hotel on Friday, May 11, 1934, at 8.30 P. M., with 48 members present.

The Secretary read a letter from Dr. J. B. Morrison, Secretary of the State Society, requesting that the Society elect a delegate to the State Society to fill the unexpired term of Dr. W. Blair Stewart, deceased. Dr. C. H. de T. Shivers was elected, his term expiring in 1936.

The Secretary also read a letter from the State Secretary stating that dues would have to be paid by this Society for its Honorary Members if their names are to appear in the official list. Dr. Irvin suggested that the delegates to the coming Convention be instructed to protest this action. This was put in the form of a motion and regularly passed.

A letter was read from the Bergen County Society containing a resolution opposing any reduction in the State Society dues. A motion was passed to acknowledge receipt of and file this communication.

A letter from the Executive Secretary, Dr. Wilkes, containing a list of bills before the Legislature which should have the attention of every member of the Society was read:

A313: A bill to retain to the professional boards funds collected by them heretofore used for the work of practitioners of medicine in this State.

A4-6: Bills to aid in the detection of tuberculosis in pupils and teachers in the schools.

S183: Concerning the use of the title of Doctor—This will restrict any but doctors of medicine and dentistry from using this title.

These three bills should be passed and the members of the Society were urged to give their support to this legislation.

S22: The Beautician's Bill should be defeated.

A303: Establishing a separate license for the different cults should be defeated.

S73: A vicious osteopathy bill, to be defeated.

S207: A Bill for the licensing of chiropractors, based on preliminary education and five years practice with a reputable physician should be defeated.

Dr. Conaway made a motion which was carried that the Secretary should write a letter to the Legislators of this County concerning the above bills, approving the first three, and asking them to vote against the others and to notify the State Secretary of this action by the Society.

Dr. Louis M. Rodi was elected to active membership in the Society.

Dr. J. S. Irvin reported for the Medical Advisory Committee that school physicians are now permitted to treat E. R. A. patients, but that all others holding state and municipal positions were barred.

He also stated that he had heard a rumor that E. R. A. medical work is to be restricted to emer-

gency cases only, and that all other cases were to be taken care of by the city physicians.

Dr. Harry Subin reported that there had been a very good response to the outing, and that the Committee hoped that everyone would attend.

Dr. D. B. Allman stated that Bill S136—the Physicians Lien Bill—had passed and was now a law. After all the details are worked out and the schedule of fees are recorded with the County Clerk, every physician treating these liability cases will be provided for.

Dr. Conaway stated that the delegates from the State Society were to be elected at the coming Convention. The present delegates are Dr. J. F. Hagerty and Dr. W. P. Conaway. A motion was made and passed approving the re-election of the present delegates.

Dr. Conaway also stated that it was South Jersey's turn to elect a third Vice-President to the State Society and that Dr. W. E. Darnall was the next in line for that office. It was moved and seconded that our delegates be instructed to support Dr. Darnall at the coming Convention.

Dr. W. P. Healy, Gynecologist to the Memorial Hospital, New York, presented a lantern slide demonstration on "The Early Diagnosis and Treatment of Cancer of the Female Pelvic Organs".

The paper was discussed by Drs. Conaway, Westcott, Carrington, Roop and Kilduffe.

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held May 8 at the Holy Name Hospital, Englewood.

The following were elected to Regular Membership: Richmond Douglass, of Englewood; A. Barroso-Bernier, of Englewood; Enrique del C. Smaïne, of Carlstadt.

The Secretary read the applications for Junior Membership of Dr. Joseph M. Coppoletta, of Cliffside Park, and Dr. H. Oren, of the Hackensack Hospital.

The Secretary mentioned the following communications:

A letter from Dr. Stanley Nichols announcing a meeting of Public Health Committees in Newark on May 16.

A letter from Dr. William K. Campbell, Chairman, Committee on Arts and Hobbies, asking for entries for the Exhibit at the State Convention in June.

A letter received from Dr. Morrison, Secretary of the State Society, stated that the Bergen County Medical Society was entitled to eleven Delegates on the basis of 160 paid-up members.

Legislative Bulletin No. 6. Particular attention was called to Assembly Bill A1303 which was reported out of committee on April 30. This Bill, if passed, would establish a separate board for the cults.

The following recommendations as to birth control and birth control clinics were discussed by Dr.

R. K. Tether and passed unanimously after motion by Drs. Corn and S. Alexander:

It is recommended that the Bergen County Medical Society go publicly on record as approving of birth control as specified in the laws of New Jersey.

It is recommended that the rules for clinics as adopted by the four hospitals of Bergen County and the Bergen County Medical Society be applied to Birth Control and Maternal Health Clinics.

The tentative set of rules in regard to clinics, patients and doctors as submitted by Dr. R. K. Tether, Chairman of the Clinic Committee, were postponed for further consideration at a later meeting.

Dr. S. T. Snedecor spoke upon the passing and signing of the "Doctors' Lien Bill". He was very much impressed by the effect of the active participation of the doctors in procuring proper legislation.

Mr. Whitehead called attention to the list of reporting health officers as printed in the Bulletin.

The Secretary called attention to the fact that the delegation to the State Convention should be completed to fill out the quota of eleven allowed us.

The meeting was then turned over to Dr. George M. Levitas, Chairman of the Scientific Committee, who introduced the speakers of the evening.

Dr. A. J. Casselman, Consultant, Venereal Disease Bureau, New Jersey State Department of Health, spoke on "Coöperation in the Control of Gonorrhea and Syphilis". He explained the effort of the State Department of Health in helping the doctors.

Dr. P. S. Pelouze, Professor of Urology, University of Pennsylvania Medical School, spoke on "Gonorrhea in Male and Its Treatment".

ANNUAL SPRING OUTING

The annual Spring outing of the *Bergen County Medical Society* was held at Bergen Pines, May 20, beginning with sports at 2:30 p. m.

At 5 p. m. the doctors went from their various sports to the Tuberculosis Pavilion where a regular meeting was held.

The business was much abbreviated, and was as follows:

Dr. Helen Moran, of Englewood, was elected to regular membership from Associate.

Drs. Joseph M. Coppoletta and Hyman Oren were elected to junior membership.

The following communications were mentioned:

1. A letter from Dr. L. A. Wilkes asking all the delegates to become familiar with the reports of the State Medical Society committees.

2. The report of the Sub-committee of the Hospital and Medical Education Committee of the State Medical Society proposing:

a. Control of all hospitals under the State Department of Institutions and Agencies, and

b. This to be followed up by regulations as to the relationship of the Professional Staff to the hospital.

3. A letter from Dr. Quigley urging that our society prepare a scale of fees according to the Doctors' Lien Bill.

4. A letter from Dr. Wilkes suggesting that we

send out a proposed form letter intending to enlist the support and coöperation of other health workers in our Public Health program.

5. A letter from Dr. Wilkes asking us to act immediately to have a physician named on the new County Advisory Committee to the Emergency Relief Administration. This committee had already been appointed and no doctor was listed.

The meeting was then turned over to Dr. J. Morrow, Superintendent of Bergen Pines, who reported on the Convention of National Tuberculosis Association.

Dr. G. W. Finke reported on the surgical work being done at Bergen Pines by Drs. Spickers, Anderson, and himself.

Dr. J. B. Edwards compared the regular x-ray films with the paper plates and pointed out the indistinctiveness of the paper ones.

Drs. Baylock and Alcemo showed x-rays and presented two cases which had responded well to frequent pneumothorax treatments.

Dr. J. Morrow introduced Dr. William Francis Honin, Surgeon and Medical Director of the Metropolitan and Sea View Hospitals of New York, who classified tuberculosis according to pathological lesions into:

1. The acute exudative,
2. The caseous pneumonic,
3. The exudative productive, and
4. The chronic proliferative.

He showed lantern slide demonstrations of these lesions, and then with the aid of a moving picture of a thoracoplasty operation, he described the many operative procedures used in chosen cases of tuberculosis.

The meeting was then adjourned to a buffet supper in the main building.

CAMDEN COUNTY

Vincent Del Duca, M.D., Reporter

The May meeting of the *Camden County Medical Society* was held in the West Jersey Homeopathic Hospital May 1, 1934, at 9 p. m., the President, Dr. T. B. Lee, presiding.

The Society was welcomed to the Hospital by Dr. Earl Hallinger, Chief of the Staff.

Dr. Robert Sheppard, 763 North 27th Street, Camden, N. J., was unanimously elected to membership.

The President announced that the Annual Outing of the Society would be held on June 14th, 1934, at Tavistock Country Club—golf in the afternoon, dinner and a social evening.

He also announced that the Society had accepted an invitation from the Staff of the Jeannes Hospital in Fox Chase, to visit this Hospital on June 20th, 1934.

There being no further official business, the meeting was turned over to the staff of the entertaining hospital, which presented the following program:

"Series of Glaucoma", A. M. K. Maldels, M.D.; "Complete Vaginal Enterocoele Complicating Labor", Frank Moore, M.D.; "Coronary Thrombosis with Rupture of the Heart", Harold K. Eynon, M.D.; "Case of Emphysema of Throat Following Tonsillectomy", Earl Hallinger, M.D.; "Encephalitis with Parkinson's Syndrome", Penrose Thompson, M.D.;

"Case of Fractured Vertebrae", Stanley L. Brown, M.D.; "Puerperal Streptococemia Treated by Immune Transfusions", Grant Favorite, M.D.; "Dehydration Feeding Applied on a Case of Hydrocephalus Occurring with Meningocele", Harry B. Marks, M.D.; "Adeno-Carcinoma of Fundus Uteri", Edmund C. Hessert, M.D.; "Mesenteric Thrombosis and Multiple Intestinal Perforations", Wesley J. Barrett, M.D.; "Three Cases of Paresis Treated by Malaria with Apparent Recovery", Lawrence W. Hicks, M.D.; "A Case of Atypical Ectopic Pregnancy", Charles F. Hadley, M.D.; "Two Cases Splenectomy as a Result of Traumatic Rupture, Recovery", H. Wesley Jack, M.D.; "Ureteral Calculus—Brief Report on Two Operative Cases", Leon Ashcraft, M.D.

At the conclusion of the program, a delightful buffet supper was served, and a pleasant social hour enjoyed.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

President Edward W. Sprague presided at the meeting Thursday evening, May 10, 1934, at the Academy of Medicine, Newark. Secretary Frank W. Pinneo read the minutes of the last meeting and also a summary of the actions of the Council for the information of the membership.

The society approved the increase of the maximum amount available from its fund for relief of needy physicians from \$30 to \$50 per month.

Dr. Henry C. Barkhorn on behalf of the Medical Advisory Committee to the Emergency Relief Administration reported that the plan is working well, and that the physicians are cooperating. The committee recommended that a letter be sent to the superintendent and to the social service department of each hospital and clinic suggesting that the following question be added to the ones now asked:

"Have you had a doctor?" If the answer is "No", admit the patient to the clinic.

If a doctor's name is mentioned, ask: "Are you willing to get E. R. A. authorization so that you may go to him and he may be paid?" If the answer is "Yes", refer the patient to the local E. R. A. headquarters; if "No", admit the patient to the clinic.

The amounts of the E. R. A. bills for medical services in Essex County have been as follows:

February, \$2400.00; March, \$4500.00; and April, \$6100.00.

Paid in Essex County: March, \$3316.00; and April, \$5800.00.

Dr. Barkhorn advised that the diagnosis of each patient be carefully completed. If the condition is an "acute exacerbation", it should be so stated, as authorization differs in acute and chronic cases.

Chairman Lowrey of the Economics Committee, Areson of the Hospital Committee, and Edgar III of Public Health Committee gave reports.

Chairman William H. Areson reported the successful activities of the Welfare Committee in securing favorable action on legislative problems in Trenton. In view of the magnitude of the work

and the successful results obtained, this report was enthusiastically received, and the Chairman commended.

The following members were elected:

Regular—Anthony F. DePalma, Charles C. Feneck, Richard B. Graham and Spurgeon Sparks.

Associate—Everett O. Bauman, Louis I. King, Charles R. Walsh and William Zimmer.

After adjournment of the Society meeting, the Delegates to the Annual State Meeting organized, electing Edward W. Sprague Chairman, and Frank W. Pinneo Secretary. They also discussed policies to be advocated and supported.

The Academy of Medicine of Northern New Jersey

EYE, EAR, NOSE AND THROAT SECTION

A. Russell Sherman, M.D., Secretary

A regular meeting of the Eye, Ear, Nose and Throat Section of the Academy of Medicine of Northern New Jersey was held Monday, April 9, with the Chairman, Dr. Browne Morgan, presiding, and thirty members present.

The following officers were elected:

Chairman, Alfred Stahl; Secretary, A. Russell Sherman.

Dr. Lyndon A. Peer demonstrated a patient who had had a congenital absence of one nostril, and who was having a new one constructed by means of a bony opening through the location of the maxillary antrum (also absent) and by a skin flap from the forehead.

Dr. B. B. Adelman demonstrated a boy who had a sclerosing osteitis of the orbit caused by a foreign body. (See page for a description of the case).

Dr. Hughes demonstrated a patient, recently operated on, who had had a dermoid cyst of the orbit removed by a Kronlein operation.

The guest of the evening, Dr. Algernon B. Reese, of New York, gave an informal talk on some practical features of certain external eye diseases.

SECTION OF MEDICINE AND PEDIATRICS

Benjamin Saslow, M.D., Secretary

The 172nd monthly meeting of the Section of Medicine and Pediatrics of the Academy of Medicine of Northern New Jersey was held at the Academy of Medicine on April 19 at 9 p. m., with Dr. A. W. Bingham, President of the Academy, in the chair. The present officers of the Section, Drs. Jacob Polevski, Chairman, and Benjamin Saslow, Secretary, were reelected for 1935.

Dr. Polevski introduced the speaker of the evening, Dr. John Wyckoff, Dean, and Professor of Medicine at the University and Bellevue Medical College. His subject was "Paroxysmal Tachycardia of Ectopic Origin".

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The members of the Gloucester County Medical Society met on the evening of May 17, at Hotel Pitman for the final meeting until September.

After hearing reports of committees, the mem-

bers were addressed by Dr. Robert Sterner, assistant professor of the Temple University School of Medicine. His talk was based on the topic "Newer Aspects of Gall-Bladder Disease with Especial Emphasis on Diagnosis and Treatment."

Members who attended the meeting were: Drs. B. A. Livengood and Spear, of Swedesboro; J. H. Underwood, Elwood E. Downs, C. A. Bowersox, Dorothy Rogers, Fuller G. Sherman, Paul M. Pegau, H. B. Diverty, of Woodbury; H. L. Sinexon, C. C. Sheets, of Paulsboro; I. W. Knight, Victor I. Barrows, M. F. Lummis, of Pitman; C. C. Pedrick, Glassboro; H. W. Wright, Williamstown; Louis Ruttenberg, Mantua; T. M. Gairdner, W. W. Pedrick, Glassboro; Samuel F. Ashcraft, Mullica Hill; E. L. Ristine and R. K. Hollinshed, of Westville; C. I. Ulmer, of Gibbstown; Dr. Harris, Mullica Hill; Frederick G. Wandell, of Clayton, and Duncan Campbell, of Woodbury. Dr. Oram Kline, of Woodbury attended the meeting as a delegate from Camden county.

MONMOUTH COUNTY

Samuel Edelson, M.D., Reporter

The May meeting of the *Monmouth County Medical Society* was held at the Berkeley-Carteret Hotel, Asbury Park, on April 25, 1934. The president, Dr. J. E. Maher presiding.

The following executive committee report was read:

"A meeting of the Executive Committee of the Monmouth County Medical Society was held at the Monmouth Memorial Hospital, Long Branch, on Monday evening, April 9, 1934, with nine members present: Drs. Rullman, Gosling, Parry, Watkins, Herrman, Altshul, Fairbanks, Blaisdell and Featherston.

"Dr. William G. Herrman, Chairman of the Economic Committee, presented the plan of the Monmouth Service Company of Long Branch to finance medical bills. This plan was discussed from all angles, and as several questions arose, the Secretary was instructed to obtain additional information from the company. The Economic Committee will investigate the credit rating of the finance company in New York which would supply the funds for financing the bills. The Economic Committee will also obtain a report from the American Medical Association so that at the next meeting the material will be reviewed before presenting the plan to the entire membership.

"The Medical Advisory Committee approved the applications of the following doctors to serve under the Medical Agreement between the State Emergency Relief and the Monmouth County Medical Society, Dr. Marc Krohn, Dr. H. F. Cooley, Dr. J. C. Offerman. The Secretary was instructed to so notify the County Director.

"Dr. James A. Fisher, Councilor of the Fourth Judicial District, requested a report on the workings of the E. R. A. in this county. The Secretary was instructed to submit a written report to Dr. Fisher, which will be presented at a meeting

of the Judicial Council with the Chairman of the E. R. A. Committee.

"Dr. William G. Herrman brought up the subject of unsatisfactory dealings with certain law firms in the county and state. It was suggested that a list of such firms be available to all the members of the Medical Society. It was voted to notify the Monmouth County Bar Association of our action.

"A discussion took place relative to the treatment of people receiving aid under the E. R. A. at the Hospital clinics. It was moved by Dr. Parry, seconded by Dr. Watkins, and carried that the Society name a committee to wait upon the Boards of Governors at the Fitkin Memorial and Long Branch Memorial Hospitals to inform them it is our opinion that the members of the County Medical Society will refuse to treat E. R. A. cases in the hospital clinics.

"A communication was read from Dr. Leo Haggerty, Chairman of the Committee on Legislation, concerning Bill S. 136, better known as the Physician's Lien Bill. This bill passed the Senate in an amendment form and is now up for vote in the Assembly. In the event that the bill is passed and becomes a law, it will be necessary for the County Medical Society to draw up a schedule of fees, which will be filed with the County Clerk after a public hearing before a Judge of the Court of Common Pleas. This schedule of fees may be introduced in evidence of the reasonable value of medical and surgical services rendered in liability cases in litigation.

"It was moved by Dr. Nichols, seconded by Dr. Watkins, and carried that the Medical Society appropriate not more than \$100 for a Social Service investigation of patients treated in the wards and clinics of the Monmouth Memorial and Fitkin Memorial Hospitals. It is planned to investigate 500 cases from each hospital in an effort to ascertain the percentage of patients receiving free treatment who are not only able to pay the hospital rates, but who could afford to pay for medical services.

"Dr. Watkins also informed the Committee that the name of Dr. Stanley Nichols would be submitted to the Governor for membership on the State Board of Health. The Secretary was requested to write a letter to Governor Moore in support of this appointment."

The Secretary reported that the cost of a Social Service investigation would greatly exceed the amount stipulated in the Executive Committee report. It was moved to allow the \$25 for the committee, on immunization.

Dr. Francis Homan, Keyport, and Dr. James W. Parker, Red Bank, were admitted to membership in the County Society.

The Scientific Session of the society was held in conjunction with the meeting of the Fourth Council District. This district is composed of Camden, Burlington, Ocean and Monmouth. Dr. James A. Fisher, Councilor of the District, presided.

The following representatives of The Medical Society of New Jersey were introduced:

Dr. Frederic J. Quigley, President.

Dr. Marcus Newcomb, First Vice-President.

Drs. C. C. Beling, F. G. Scammell and S. T. Snedecor, Councilors.

Dr. LeRoy A. Wilkes, Executive Secretary.

Dr. Frank Overton, Editor.

The speakers of the evening, Dr. Edward Chamberline and Dr. Barton R. Young, Department of Radiology of Temple University, were introduced by Dr. William G. Herrman. The subject of the speakers was "Hodgkins Disease, Lymphosarcoma and Leukemia". Clinical histories, including x-ray photographs, and biopsy and autopsy findings were demonstrated and discussed with remarkable clearness and conciseness.

The speakers alternated in their remarks, Dr. Chamberline leading, and Dr. Young giving the clinical reports, while each suggested questions for the other to answer. The method gave each speaker time for reflection while the other was talking, and an opportunity to put his own remarks in logical sequence.

Fitkin Memorial Hospital

The following was the program of the Clinical Conference at the Fitkin Memorial Hospital, May 6, 1934:

1. Perforation of the sigmoid.
2. Ruptured ulcer in tuberculous patient.
3. Broncho-pneumonia in luetic patient.
4. Osteomyelitis.
5. Cardiac disease.

Monmouth Memorial Hospital

The Clinical Conference at the Monmouth Memorial Hospital, May 16, 1934, carried out the following program:

1. Addison's disease with pigmentation.
2. T. B. Hip, t. b. ischio-rectal abscess, t. b. polyserositis. Enlarged heart with destruction of most of heart muscle and replacement by numerous tubercles.
3. Renal function tests applied to a specific case.
4. Lobar pneumonia.
5. Gonococcus ophthalmia.
6. Placenta praevia.
7. Septic abortions.
8. Transfusion accidents.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A meeting of the *Morris County Medical Society* was held the evening of May 17 at the State Hospital at Greystone Park. President Frost presided over a very gratifying attendance of between 65 and 70 members.

The magnet of the evening was Dr. Frederick T. vanBuren, Jr., Professor of Clinical Surgery at Columbia University, whose timely topic was "Relation of the Hospital to the Public". The speaker presented his subject in a manner that was stimulative of thought and interest in this very real problem both from the standpoint of the hospital and the physician, stressing the necessity of in-

forming the public of the community service rendered by the hospital, and of its needs; and of correcting the various false impressions in the minds of the public. He emphasized the value of a clear, simple, and understandable *publicity campaign*, and of suggestions for bringing the public in to close coöperation with the hospital. He cited various misunderstandings which are based on lack of information. He did not know of any hospital at the present time that is not running behind in its finances, but the general public does not know that.

Dr. vanBuren's address aroused a great deal of discussion which was participated in by Drs. Lathrope, Glazebrook, McMahon, Krauss, Pinckney, Haven, Rice, Costello and Frost, all of whom contributed suggestions for consideration. After the discussion, Dr. vanBuren answered various questions raised.

The subject of the call of the meeting having been concluded and adjournment taken, President Frost granted the privilege of the floor to Dr. Elvira Dean Abell, who presented a pressing public health program for diphtheria immunization and small-pox vaccination of school children and children of pre-school age. Dr. Abell outlined the plan in a very lucid way and stressed that it was a plan developed by the State Medical Society, and that its success depended upon the coöperation of every doctor in the county; explaining how the vaccines and anti-toxins would be furnished free for this plan, and the "public health hour" to be set aside by the physicians to do the work in their offices at these times so as distinctly to separate it from their regular practice. The plan was so clearly presented that when the attitude of the members was called for by their rising, the plan was unanimously approved, and the sense of the members indicated that when cards are mailed to the members, they will be returned with a 100 per cent agreement.

A very interesting evening was brought to a conclusion by refreshments which were served in the hospital cafeteria.

OCEAN COUNTY

Eugene Herbener, M.D., Reporter

The regular meeting of the *Ocean County Medical Society* was held at Eno's Forked River House on Wednesday, May 6, 1934, beginning with a shore dinner at 6:30 p. m.

The President, Dr. Abraham Goldstein, called the business meeting to order at 9 p. m. Nineteen members and one guest, Dr. B. Hendrickson, answered to the roll call.

The Secretary read the communications, which were referred to their respective committees with instructions for each committee to render their report at the next regular meeting.

A change in the By-Laws was adopted providing for monthly meetings except during the summer months.

Matters pertaining to the Emergency Relief were discussed and referred to the Emergency Relief Committee for final action.

Woman's Auxiliary

Atlantic County

Reported by Mrs. James H. Mason

The regular meeting of the Woman's Auxiliary to the Atlantic County Medical Society was held at the home of the President, Mrs. James North, May 11, at 2 p. m., with nineteen members present. The members of the Auxiliary were invited to attend a Mother's Day program at the Betty Bacharach Home for Crippled Children. Congressman Mary Norton was the speaker.

The annual luncheon bridge was held at the Hotel Claridge May 9, with seventy-one attending.

It was moved and carried that a card party be held during the summer to raise money to purchase presidents' pins for the Past Presidents. Mrs. David B. Allman, Chairman of Entertainment, was chosen to make the arrangements.

After the business meeting, cards were enjoyed and refreshments were served by the officers, who were hostesses for the day, Mrs. James North, President; Mrs. Carl Surran, First Vice-President; Mrs. Daniel Reyner, Second Vice-President; Mrs. Lawrence A. Wilson, Recording Secretary; and Mrs. Robert A. Bradley, Treasurer.

Gloucester County

Reported by Mrs. Henry B. Diverty

The Woman's Auxiliary to the Gloucester County Medical Society held its annual meeting yesterday, May 15, at Hotel Pitman, Pitman, N. J.

Members and their guests came in automobiles from various parts of the county, arriving in time for luncheon at 1 p. m. A business meeting immediately followed the luncheon.

Result of election of officers was as follows: President, Mrs. J. Harris Underwood; Vice-President, Mrs. Fuller Sherman; Secretary, Mrs. Paul Pegau; Treasurer, Mrs. David Brewer.

After adjournment games were played. The prizes awarded were baskets of pansy plants covered with huge blossoms of varied coloring.

Hudson County

Reported by Caroline Culver

The regular monthly meeting of the Woman's Auxiliary to the Hudson County Medical Society was held at the Y. W. C. A. Building, on the afternoon of Monday, May 7, with the President, Mrs. Frank P. Nicholson, presiding.

The minutes of the previous meeting were read and approved.

The Treasurer and the Corresponding Secretary reported.

The date of our Spring Luncheon having been changed to Monday, May 21, at Arcola Country Club, the Chairman asked us to note the time—12 o'clock.

A group has been appointed to greet the members upon their arrival.

The President spoke of the New Jersey State Medical Convention to be held at Haddon Hall, Atlantic City, on June 5, 6, 7, and appointed the Delegates and Alternates as follows: Mrs. John Nevin, Mrs. William Freile, Mrs. Edward Waters, Mrs. George M. Cluver, Mrs. Frank P. Nicholson, Mrs. P. Maras, Mrs. Charles Kelley, Mrs. Berthold Schwarz, Mrs. William Barbarito and Mrs. A. Jaffin.

Mention was made of the Hobby Exhibit and members urged to make entree, if possible.

The speaker for the afternoon was Dr. Berthold T. D. Schwarz, of the Hudson County Medical Society, his subject being "The Widows' and Orphans' Relief Fund".

Dr. Schwarz discussed this in detail and urged the members to interest their husbands to join.

Questions, and a social hour followed, when Mrs. Schwarz, as Chairman of hostesses, and an able committee served ice cream and cake.

In closing, Mrs. Nicholson thanked the Auxiliary members very graciously for their hearty coöperation and support during her first year as President.

The meeting then adjourned until the first Monday in October.

Obituaries

ERNST THUM, M.D.

Dr. Ernst Thum, aged 55, of 819 Avenue C, Bayonne physician, died on May 31, 1934, at the Neurological Institute, New York, after four weeks' illness. Dr. Thum, a specialist in eye, ear, nose and throat work, was taken to the hospital last Friday when his condition became critical.

Dr. Thum was born in New York November 9, 1878, but received his early education in Darmstadt, Germany. He received his medical diploma from the New York University and Bellevue Medical College in 1899. He served a two-year internship in the Metropolitan Hospital, Blackwell's Island, New York City, and has practiced medicine in Bayonne ever since. He was on the staffs of the local hospitals and an instructor in nose and throat work in the Post-Graduate Hospital, New York.

He was a fellow in the American College of Sur-

geons, a member of the Bayonne, Hudson County and New Jersey Medical Societies, Practitioners' Club of Hudson County, New Jersey Physicians' and Surgeons' Club and the Yountakah Country Club. He was an organizer and President of the Bayonne League of Hard of Hearing.

CLARENCE V. BUMSTED, M.D.

Dr. Clarence Van Reynegom Bumsted, 55, died on May 27, 1934, at his home, 62 Heller Parkway, Newark. He had been ill several months and had suffered a stroke. He was a specialist on tuberculosis.

Born in Jersey City, Dr. Bumsted was the son of the late Joseph H. and Frances Van Reynegom Bumsted. He was graduated from Brown University in 1903 and received his medical degree from the University of Pennsylvania four years later.

He served his internship in Episcopal Hospital, Philadelphia.

Dr. Bumsted was Assistant Attending Physician in Newark Memorial Hospital from 1910 to 1915 and since 1918 had been Attending Physician in St. Barnabas' Hospital. His Summer home was at Lake Placid and he had been Attending Physician in Lake Placid General Hospital since 1924. He was appointed Consulting Physician on diseases of the chest in Babies' Hospital in 1925, in Essex Mountain Sanatorium in 1922 and in Presbyterian Hospital in 1928.

During the World War, Dr. Bumsted was a member of Selective Advisory Board No. 1 of the Mayor's Committee for National Defense. He was a member of many national, state and local medical societies, the Practitioners' Club of Newark, Forest Hill Golf Club and Essex County Country Club. He was the author of many articles on internal medicine.

Dr. Bumsted was married in 1908 to Miss Mary Wenty. Besides his wife, he leaves a son and two daughters.

GEORGE W. VAN NESTE, M.D.

Dr. George V. VanNeste, a prominent physician, of Hopewell, N. J., died suddenly from a heart condition on May 9, 1934, while playing cards at the house of a neighbor. He was in his seventy-eighth year, and had practiced medicine in Hopewell for more than thirty years.

Dr. VanNeste, who was born and raised at Weston, N. J., was a graduate of Rutgers, and of Jefferson Medical College. He practiced medicine at Millstone for a number of years before establishing himself at Hopewell.

ALEXANDER MARCY, M.D.

Dr. Alexander Marcy, retired physician and banker, died at his home in Riverton, N. J., on May 1, 1934, in his seventy-fifth year. He was President of the New Jersey Medical Society in 1906.

A member of a family which included many physicians, Dr. Marcy was born at Cold Springs, near Cape May. He was graduated from the University of Pennsylvania in 1881. Dr. Marcy was an organizer and later President of the Cinnaminson National Bank. He traveled considerably and retired several years ago from active medical practice and business.

Surviving are two daughters, Mrs. F. Raymond Wellinger, of Chestnut Hill, Pa., and Mrs. J. Gardner Crowell, of Riverton.

VICTOR MRAVLAV, M.D.

Dr. Victor Mravlag, one of the most prominent citizens of Elizabeth, died on May 15, 1934, in the eighty-sixth year of his age. He was a native of Austria, and received his medical education in the University of Vienna. He came to the United States in 1873 and made Elizabeth his home, and practiced medicine there for over fifty years. He engaged in hospital work and was surgeon to the Pennsylvania Railroad. He was proud of the fact that he had attended more than 4000 births. He served as Mayor of Elizabeth for twelve years.

Not unlike William Osler and like his friend Abraham Jacobi, he belonged to the great pathfinders. With the highest ideals, courageous and progressive, he followed the enormous strides that medicine made during his lifetime.

Communication

ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

The Academy of Medicine of Northern New Jersey is making an effort to increase its membership. It is realized that this is not the ideal time to undertake a drive, because of economic conditions; and so the Council has created a new class of membership termed "Junior Fellowship", and invites every qualified physician and dentist in Northern New Jersey, whose license to practice in the State of New Jersey is not yet five years old, to become a *Junior Fellow*. No dues or expense is attached to this new class of membership. When the Junior Fellow's license becomes five years old, it is hoped he will become a Fellow, at which time annual dues will begin.

The Academy was founded in 1911, and was chartered by the State of New Jersey as a central body for the dissemination of knowledge of the sciences by means of lectures, courses, clinics and other measures, to advance the cause of medical practice for the aid of suffering humanity. We now have 450 members, and the best medical library in the State. The books and over 100 periodicals

circulate among the members upon request. There is a full-time librarian who will assist in securing data for papers. Information from other libraries may be secured.

In addition to the stated meetings, the activities of the Academy are divided into Sections: Medicine, Surgery, Obstetrics and Gynecology, and Eye, Ear, Nose and Throat.

Progress in our professions must accrue by attendance at clinics, demonstrations, and the many activities of a real Academy of Medicine. Our organization is the result of careful planning by men of vision, and the Academy has been made the central administrative body for the radiation of every activity along the lines of our scientific endeavor.

We invite every physician in Northern New Jersey to enroll in our membership, not in a passive, indifferent manner, but as an active, participating unit.

Information will gladly be given by the Committee on Admission. Dr. B. E. Failing, 31 Lincoln Park, Newark; Dr. J. Wallace Hurff, 86 Washington Street, Newark, or Dr. Donal Miner, 921 Bergen Avenue, Jersey City.

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VIEW OF THE GROUNDS



APPROACH

BOOKLET AND TERMS ON REQUEST

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COCOMALT

The importance of milk as part of the dietary in post-operative and convalescent cases cannot be over-estimated. It is—and rightly so—the principle dependence of the diet.

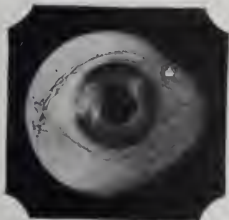
But many patients have a natural dislike for milk, and others soon grow tired of the monotony of milk * * * milk * * * milk * * * day after day.

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Fourth District (Camden, Burlington, Ocean and Monmouth Counties)	JAMES A. FISHER, Asbury Park (1936)
Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties)	ALDRICH C. CROWE, Ocean City (1935)

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Delegates to the American Medical Association		Alternate Delegates	
WALT P. CONAWAY	Term expires 1934	PHILIP MARVEL	Term expires 1934
JOHN F. HAGERTY	" " 1934	GEORGE H. SEXSMITH	" " 1934
E. R. MULFORD	" " 1935	S. B. ENGLISH	" " 1935
A. HAINES LIPPINCOTT	" " 1935	STEPHEN T. QUINN	" " 1935

SCIENTIFIC SECTIONS

Chairmen for the Annual Meeting of 1934

Section Chairman

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Pediatrics ..	WALTER B. STEWART, 8 N. Tallahassee Ave., At. C'y
Radiology ..	GEO. S. REITTER, 144 Harrison St., East Orange
School Physicians ..	A. G. IRELAND, Trenton Trust Bldg., Tr'n

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LOUIS C. LANGE , <i>Chm.</i> , Weehawken	Term expires 1934
RALPH K. HOLLINSHED , Westville	" " 1935
CLARENCE C. ANDREWS , Atlantic City	" " 1934

Committee on Publication

HENRY C. BARKHORN , <i>Chm.</i> , Newark	Term expires 1936
EDWARD J. ILL , Newark	" " 1934
LINN EMERSON , Orange	" " 1935
FREDERIC J. QUIGLEY	Ex-officio
J. BENNETT MORRISON	Ex-officio

Committee on Finance and Budget

HARRY R. NORTH , <i>Chm.</i> , Trenton	Term expires 1939
ALFRED STAHL	" " 1934
JAMES S. GREEN	" " 1935
HERSCHEL PETTIT	" " 1936
WILLIAM G. HERRMAN	" " 1937
WILLIAM J. SWEENEY	" " 1938

Committee on Program and Arrangements

WILLIAM J. CARRINGTON , <i>Chm.</i> , Atl. City	Term expires 1935
JOHN W. GRAY , Newark	" " 1934
WILLIAM D. OLMSTEAD , Atlantic City	" " 1936
FREDERIC J. QUIGLEY , Union City	Ex-officio
J. BENNETT MORRISON , Newark	Ex-officio

Committee on Honorary Membership

THOMAS W. HARVEY , <i>Chm.</i>	Term expires 1934
W. E. DARNALL	" " 1935
EPHRAIM R. MULFORD	" " 1936

Committee on Hospitals and Medical Education

HARRY H. SATCHWELL , <i>Chm.</i>	Term expires 1936
WILLIAM W. BROOKE	" " 1935
ARCANGELO LIVA	" " 1934
JOHN H. CARLISLE	STUART Z. HAWKES
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WILLIAM R. LITTLE	EARL H. SNAVELY
LOUIS A. PYLE	ELMER P. WEIGEL
DAN S. RENNER	HUGH H. TYNDALL
J. VINCENT SMITH	

*Deceased.

Committee on Medical Defense

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E. REISSMAN	

Committee on Insurance

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ROBERT STOCKFISH	Jersey City
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CHESTER I. ULMER	Gibbstown
H. ROY VAN NESS	Newark
H. B. WILSON	Hackensack
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I. WARNER KNIGHT	Pitman
*F. C. JOHNSON	New Brunswick
JULIUS LEVY	Trenton
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THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Offices of the Society, 137 East State Street, Trenton, N. J.

VOL. XXXI, No. 7

JULY, 1934

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MILBANK PLAN OF SICKNESS INSURANCE

The Medical Economics Section of *Minnesota Medicine* of June briefly reviews the sickness insurance plan of the Milbank Foundation, in which Mr. John A. Kingsbury is a prominent leader. *Minnesota Medicine* of June says that the following features are urged:

1. Compulsory insurance for all persons with incomes of \$3,500 or less. (This would include many doctors.)

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PUBLICITY BY THE ARKANSAS MEDICAL SOCIETY

The June *Journal of the Arkansas Medical Society* contains the minutes of the 59th annual meeting which was held in Little Rock, April 16-18, 1934. The Committee on Publicity reported as follows:

"It is fitting that at this time the medical profession should be 'actionary', rather than 'reactionary'; and should wage an intensive campaign to inform the public of the great progress which has characterized our profession during the last decade. We have left it to the newspapers in their quest for news to publish whatever new discoveries have stood the test of research and clinical experience. We have also half-heartedly answered criticisms of our medical economics. Press dispatches headlined the accusation that 'Doctors Were Plumbers' and that 'Some 40 per cent to 60 per cent of Appendectomies Are Unnecessary.' However, Dr. Dean Lewis' answer was given but little space. We owe it to ourselves to adopt a plan of publicity which would eliminate such occurrences whose aftermaths are so potentially dangerous. With this in mind, your committee makes the following recommendations:

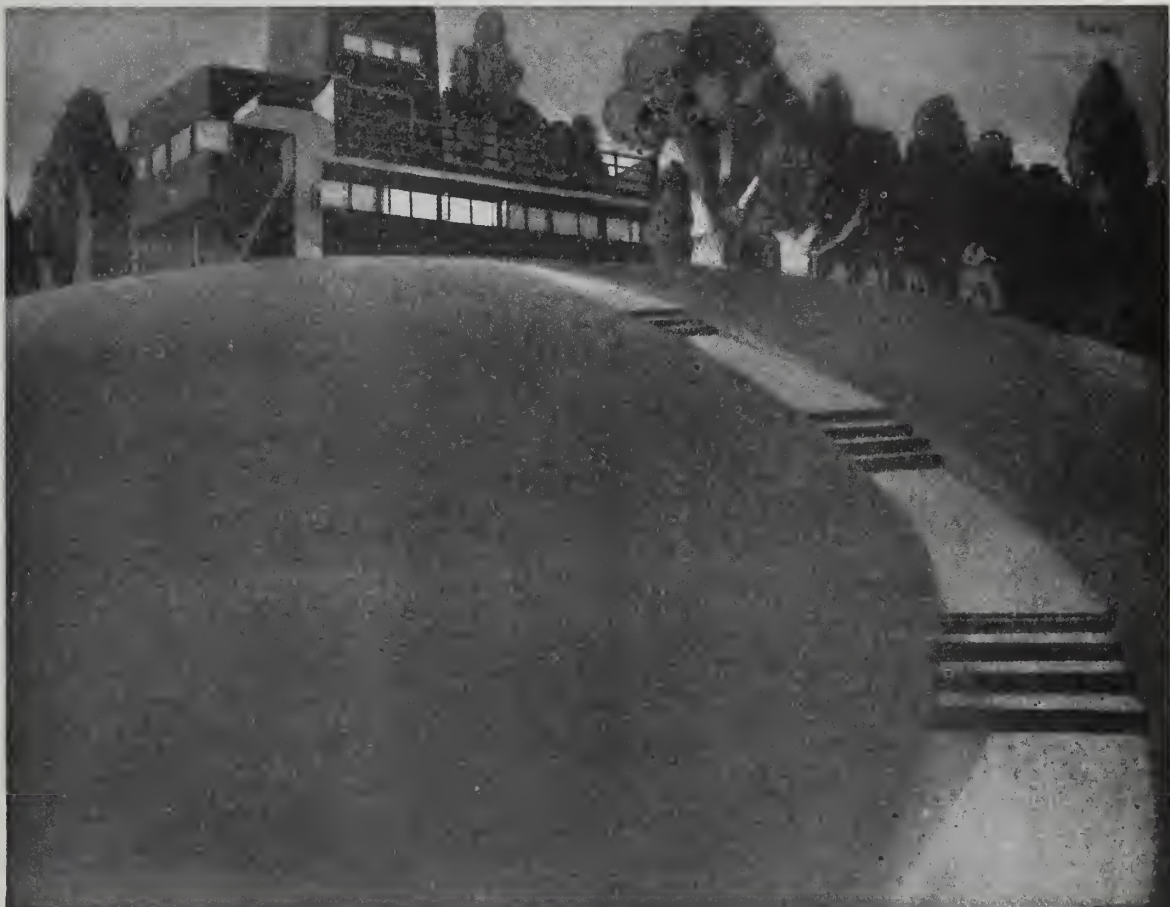
1. That the Arkansas Medical Society carry on an intensive publicity plan under the direction of a committee on publicity. This plan encompasses articles and speeches on medical progress, medical subjects of general interest, dissemination of the principles of preventive medicine, and to explain the importance of the maintenance of high ethical standards.

2. This program to be carried out by several methods, each of which may be used.

The first method is utilization of the newspapers for short concise articles written by various members at the request of the committee and distributed by it. These should be given out as under the auspices of the committee on publicity of the Arkansas Medical Society.

The second method is through the effective working of a Speakers' Bureau. The committee has in mind the organization of a State Speakers' Bureau. This would be composed of physicians selected by the committee because of their ability as speakers as well as for their medical knowledge. They would be used as a nucleus of a larger body which would be formed as the plan becomes workable. These men would be asked to prepare talks of various lengths on specified subjects and to hold themselves in readiness to appear on a week's notice before various civic clubs, Parent-Teacher Associations, school assemblies or public programs of various sorts. Your committee would then be in position to notify the secretary or president of a given organization, say a Parent-Teachers' Association, that it was prepared to give a series of talks on health subjects of particular value to the parents and teachers of the school child. The committee could also notify a given civic club that a capable speaker with an important civic message on health was available to address that club. We would thus be able to build up a public confidence which our silence has strained.

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But each of these statements is true only when qualified with a very important "IF"—that is, *if* the case is put into the hands of a trained physician in its early stages. As insignificant a period as one month can assume the importance of eternity—a cancer that might be cured today, may be beyond help in a single month.

How can one detect its early stages? The symptoms are so variable that it's futile, as well as dangerous, for the layman even to attempt an accurate diagnosis. But there are warnings, of which these are outstanding: a lump that won't go down . . . a sore that won't heal . . . persistent bleeding or any other persistent unnatural discharge from any part of the body . . . persistent unexplained indigestion.

These symptoms do not necessarily mean cancer. But they're reason for suspicion; and reason, therefore, to see your doctor immediately. If it *is* cancer, the tumor can, in many cases, be *completely removed* by surgery. In many others, it can be controlled by the proper use of x-ray or radium.

And if it *isn't* cancer, the relief that comes with banished fears and worries, will be a rich reward for doing the wise thing—for seeing your doctor when you first suspect that something may be wrong.

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The June *Journal of the Medical Association of the State of Alabama* discusses the blue ribbon movement among children, as follows:

Many schools throughout the nation are awarding a blue ribbon to pupils for health attainments or strivings. The object of the award is to teach the child that health is a normal quality of living rather than a formal subject to be taught. The qualifications for a blue ribbon are as follows:

1. The pupil must show evidence, first, that he is making satisfactory progress in his studies. The teacher is the judge and must certify to this requirement. A passing grade would ordinarily be acceptable. Should illness or some other unavoidable cause render a child unable to make a passing grade, however, he should not be disqualified for a blue ribbon.

2. He is amenable to the ordinary requirements of school discipline. This requirement is included for two reasons:

- a. No one wishes to give an award of merit to an incorrigible child even though he may qualify on all other counts; and

- b. It is felt that the requirements of school discipline are in a way a test to the child's potential ability to adjust himself to the demands of society.

3. He must show evidence that he is reasonably coöperative in the practice of health habits. This requirement is made to direct the attention of the child to the importance of observing health habits continuously. He must keep the daily record for one month.

4. He is free of remediable physical defects. Freedom from remedial defects is determined upon physical examination. This does not mean that the child must be physically perfect, but rather that the maximum correction or treatment shall have been attained. A child would not be ineligible if he had a defect, which, on basis of a physician's certificate, cannot be remedied further.

5. He must have been immunized against typhoid fever, diphtheria and smallpox.

To accomplish the results for which the Blue Ribbon Program was designed, the active support of school authorities, health workers, parents, children, physicians, and dentists must be obtained. Wholehearted coöperation must be acquired from lunch room directors, home economics teachers, athletic directors, nutrition specialists and janitors; from civic clubs, parent-teacher associations, the American Legion, and auxiliary groups, and all other local organizations and individuals interested in the health and welfare of children.

SECRETARY-EDITOR OF THE KANSAS MEDICAL SOCIETY

The June *Journal of the Kansas Medical Society* contains the first installment of the proceedings of the 76th annual meeting held on May 9-11, 1934. The Society has suffered a considerable loss of members. This year the Society voted to hire a full-time Secretary-Editor and establish central offices. A Society that has the courage to do this is alive and active.

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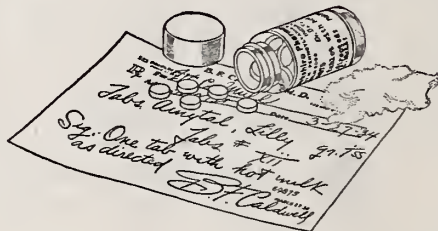
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UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



EDITOR OF
THE JOURNAL
FRANK OVERTON, M.D., Dr. P.H.

OFFICES OF THE SOCIETY—137 EAST STATE STREET, TRENTON, N. J., TEL. 9330
EXECUTIVE SECRETARY—LEROY A. WILKES, M.D.

Each member of the State Society is entitled to receive a copy of THE JOURNAL every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.

Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.

Officers, Trustees, Councilors and Committees of the Society are listed on page xx of the Advertising Section.

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EDITORIALS

The Annual Meeting in Retrospect

The Annual Meeting of every State Medical Society is a composite of three meetings:

1. That which is planned.
2. That which is actually carried out.
3. That which persists in memory.

Planning: The 168th Annual Meeting of The Medical Society of New Jersey is recorded as having been held on the three days of June 5, 6 and 7, 1934; but detailed preparations for it were started at least three months previously when every officer and committee-man began to ponder over the work which he had done during the previous year, in order to present his aspirations and accomplishments in an orderly report. Over two hundred members of the State Society participated in that preparation.

Some prepared scientific articles for the instruction of their colleagues.

Some made the physical preparations for the convenience and comfort of the participants in the actual meeting.

When the plans of the individuals were assembled, the entire meeting existed in the mind and imagination of every member who read about it in The Journal and program.

The Physical Meeting: The actual meeting was the orderly performance of the several parts for which each participant had prepared himself. It was, in fact, a drama in which the outstanding events of the medical year were reenacted by those who had borne the burden of their development and execution. Each performer had a wealth of facts and experiences on which to draw, and a company of generous co-workers to inspire him to equal or excel their accomplishments. The annual meeting was a vivid reflection of the practical activities of the members of the Society during the past year and a demonstration of their zeal and earnestness.

Inspiration: The most valuable and enduring of the trinity of the Annual Meeting is the one which remains in memory and persists as a record of accomplishments which were only hopes and aspirations during the past year. The personnel of the actors will undergo promotions, reassignments, and the introduction of new workers; but there will be no retirements, for service develops enthusiasm in which any position or rank of activity is honorable.

Comments on the Program of the Fourth Annual Meeting of the American Academy of Pediatrics

The program arranged for the Fourth Annual Meeting of the American Academy of Pediatrics held in Cleveland on June 11th and 12th, 1934, is worthy of study and careful consideration by the program committees of other medical associations.

The meetings were arranged to unify specialized interests. They were interesting and instructive and showed frankly to the members in attendance the degree of unanimity in medical opinion on each of the selected subjects under discussion as held by the highest authorities in their specialized fields of pure and applied science. The evening of each day was left free to allow the members time to digest the day's added knowledge, and to prepare for the next days' work.

There was a lack of the formal monotony which so often marks the successive reading of technical papers. There was good natured banter among the panel of discussors regarding points on which opinions differed. The professional differences of opinion which arose afforded amusement as well as instruction, so skillfully were these handled by the presiding chairmen.

Two types of meetings were provided:

1. "Round Table" discussions. These were conducted on specific subjects listed on the printed program, such as allergy, adolescence, prematurity, acute infections, and tonsillectomies. Twenty-five persons were allowed at each meeting, the admission being by card for which the doctors applied at a central office. No formal talk was given, but the chairman outlined briefly the scope of the discussion and touched upon controversial points. Three hours were allowed at each session, and the attention of the participants was sustained at all times.

2. "Panel" discussions. These might be described as a round table discussion between seven or eight selected authorities in their respective fields sitting on the platform and talking informally among themselves on the assigned topic while a large audience on the seats before them listened intently. At intervals the presiding leader would recapitulate the points of agreements and disagreements for the bene-

fit of the audience, and at the end of the period he would summarize the discussion.

The participants entered into the discussions with all the zest of an informal gathering. There were no dull moments for either the speakers or the audience, and this novel plan of presentation seemed to meet the general approval of all those present.

The subject of one discussion was "Dental Caries" and was led by Dr. Frederick F. Tisdall, Associate in Pediatrics, Department of Medicine, University of Toronto, while the other members of the group were professors from other medical and dental schools.

At another session the panel selected discussed under the able leadership of Dr. R. G. Hoskins of Harvard Union.

The American Academy of Pediatrics has clearly demonstrated that medical scientific meetings can be made interesting enough to keep the audience alert *during the entire time of each session*. A few well planned sessions, well attended and sufficiently informal to induce constructive criticism, will do as much toward clearing the atmosphere as to the present status of the medical subjects presented as long drawn out formal meetings, extending into the night.

The suggestion is here made that two sectional scientific meetings of The Medical Society of New Jersey, one in North Jersey and one in South Jersey, might prove an interesting experiment. The cost to members in attendance could be made nominal. The annual meeting of the Society in Atlantic City could be devoted more definitely to the annual reports of the officers and of the chairmen of the standing committees, the meetings of the House of Delegates, and the election of new officers. One or more scientific programs might be provided if thought advisable, but more time could profitably be provided for study of the scientific and commercial exhibits and for the promotion of fellowship among the members and their families. This is, of course, just a suggestion.

LEROY A. WILKES,
Executive Secretary.

The Medical Society and the Medical Profession

Privileges and Obligations: The State of New Jersey has conferred on physicians the exclusive right to diagnose and treat human sickness. Since physicians have accepted this monopoly of medical practice, they must also accept the accompanying obligation to devise the means and methods by which every resident may obtain every form of medical or surgical service that he needs.

No individual physician in New Jersey can be expected to have a superior knowledge or skill in all the specialties, neither can he minister to more than a small proportion of those who might need the services of medicine. Yet the broad obligation to place the services of medicine within the reach of every person is shared by every doctor. The further obligation to devise such a service rests upon the group of 4000 physicians who constitute the civic group called the *Medical Profession of New Jersey*.

Endowed "Funds" and "Foundations" are planning to make medical services universally available by the introduction of the methods of a great business corporation, whose leaders survey the field, make plans for producing and delivering the services, and hire experts to carry out the plans by the impersonal methods of business efficiency. Practitioners of medicine accept the facts disclosed by *examinations* made by competent investigators; but they are doubtful of the accuracy of the *diagnoses* made by those who have never had to make prompt decisions at the bedside; and they are suspicious of *treatments* prescribed by those who have never practiced medicine.

Physicians believe that they can develop a system of service that will be better and more practical than that devised by welfare workers; and they are assuming the leadership in that development by acting through their voluntary organizations—the Medical Societies of the Counties, the States, and the Nation.

THE MEDICAL SOCIETY

The expression, *the Medical Profession* is a mental concept, abstract and mysterious, which denotes all licensed physicians collectively. A great problem in medicine is to make that conception concrete and practical by incarnating

it in a tangible organization—the Medical Society—which is constructed after the plan of the human body, and is equipped with a mind and sensory organs, and a voice.

The units of the great system of medical societies of the counties, states, and nation are the practicing physicians who deliver the services of medicine to suffering individuals.

The *mind* of the Society is that of the officers who are chosen by their medical brethren to speak and act for them.

Its *eyes* and *ears* are those of the leaders who receive and record the impressions coming from their colleagues, and from suffering mankind.

Its *voice* is that of the medical prophets who read and interpret the signs of the times, and fire their brethren with their own inspiration to intelligent action.

The *Medical Society* is a very real personality as it expresses the sum of the motives and aspirations of its individual members. It, therefore, represents the *Medical Profession* of which every physician is a member by virtue of his license to practice medicine.

PUBLIC RELATIONS OF PHYSICIANS

A doctor is only one of a number of workers concerned with sickness and health. In the army of the United States, five men are required to take care of one sick comrade; and the proportion is still larger in civic life. A physician must, therefore, consider his public relations as he comes in contact with others who are ministering at the altars of Health and Hygeia.

A doctor treating a sick patient is the director of a series of relief services which often require the cooperation of many agencies, including nurses, pharmacists, hospitals, laboratories, welfare officials, insurance companies, fraternal orders, churches, and schools. All these agencies are essential contributors to the diagnosis and treatment of the sick, and the delivery of all other forms of modern medical service. The determination and formulation of the scope of their work and of the conditions and methods of their coöperation with physicians is a duty which belongs to the medi-

cal society as the representative of the individual physician.

THE PLACE OF THE PRACTICING PHYSICIAN

The doctor has influence with a health agency in just the degree that his relations with it are direct and personal.

His relations with the nurses and pharmacists are direct and personal, and his directions and opinions are generally accepted by them without question.

Nearly all his relations with welfare organizations are indirect and impersonal; and the principal way in which he comes in contact with them is through their field agents who act under formal orders.

A major function of the medical society is to introduce the *personal* element into the *public relations* of physicians to the other agencies engaged in the distribution of health services.

The medical society is personified and humanized in its officers and committeemen. It is equally true that the salaried officials who carry out the laws of the state, and the hired executives who promote the plans of the donors of health funds personify the governmental departments of welfare and health, and the health "Foundations".

The practical application of this fundamental principle of *personification of medical services* is that the representatives of medical societies shall meet with the representatives of the other health groups, and discuss their mutual problems on friendly terms. It is entirely proper that the medical representative should say "the Medical Society thinks", or "the Medical Society will do", so and so. The offi-

cers and committeemen *are* the medical society while they speak, or write, or act as its representatives. Boldness in asserting this fact will enhance the dignity and power of the medical profession, as well as of the individual physician.

REPRESENTATIVES OF PHYSICIANS

The distinction between the *Medical Profession* and the *Medical Society* has an importance which is not comprehended by the people generally.

Every doctor is a member of the medical profession, and can assume the privilege of speaking for it, because it is not a tangible organization. A physician who speaks, or writes, merely as a licensed doctor may put forth opinions directly opposed to those of his colleagues; but the people suppose that he represents all other physicians.

A doctor speaking for the Medical Society represents a *tangible body*, which is as real as a bank or a water company. The impressions, opinions and information which he gives out are based on actual experience and discussions within the organization; and if he misrepresents his colleagues, they can correct him or subject him to discipline.

Lay health workers are likely to forget the Medical Society as they approach an individual doctor and get his consent to serve at a clinic which the laymen are establishing. Physicians as well as laymen need to be reminded that the Medical Society is the authoritative body which will guide and direct those who seek to establish or conduct any form of health service.

The Production and Distribution of Medical Services

The service of medicine, like that of all other great services such as those of agriculture, manufacturing, transportation, light, and power, is divided into two distinct branches:

1. Production.
2. Distribution.

The Medical Profession has always been in the foremost rank in the *production* of medical services. It has ever been the fundamental article of the creed of the medical profession

that its members should engage in scientific research into the nature of the processes of life and disease, and should freely place their discoveries at the disposal of their colleagues and the public without patents, or monopolies, or restrictions of any kind. The great object of medical societies has been to teach their members how to apply the newer methods of medical practice for the benefit of suffering humanity, even though their application has

meant the destruction of the demand for their services, as it has been in eliminating typhoid fever, smallpox, and malaria—three diseases whose treatment constituted the great part of the work of the older physicians who are still in practice. It is hard to conceive how the *production* of medical services could be improved.

There is an over-abundance of medical service available in most parts of the United States. Only those persons in isolated sections of the country are shut off from expert medical attention. Yet people in metropolitan areas as well as pioneers in new settlements continue to suffer from curable forms of sickness, while many go hungry in the midst of an over-production of food. The defect in the present system of medical service is not in its *production*, but in its *distribution*.

TRENDS IN BUSINESS

The great increase in wealth and comfort which has characterized the last half century has depended on methods of *distribution* of goods and services even more than their *production*. In fact, salesmanship has outrun the capacity of the people to absorb what has been produced. The overgrowth of great corporations has resulted in *centralization* from which the trend is now toward *decentralization*, and the establishment of smaller units which are more responsive to the needs of the people.

BUSINESS METHODS IN THE DISTRIBUTION OF MEDICAL SERVICES

The service of medicine has hitherto been exempt from the disastrous consequences which have followed over-centralization in the field of business; and yet the representatives of great "Foundations" endowed with hundreds of millions of dollars are striving to introduce the methods of centralized "business" into the distribution of medical services. Their *statistical* investigations have shown that thirty millions of people in the United States are in need of medical services which they are not now receiving. The promoters would supply that need through the greatest of all centralizations of power—that of the govern-

medicine, either directly and compulsory, or through the intermediate step of insurance. The plan is revolutionary, involving untried steps and procedures.

ATTITUDE OF PHYSICIANS

Physicians generally are opposed to the plan suggested by the "Foundations" on the ground that it is neither modern, nor scientific, nor ethical.

It is not *modern*, for it is a reversion to the old system of the "Poòr" doctor serving for hire, and to that centralization which statesmen are now abandoning in other lines of human endeavor.

It is not *scientific*, for while it purports to deal with *distribution* only, it would in fact impair the *production* of medical services by removing that great incentive to study—that of achievement by superior merit and capability.

It is not *ethical* for it substitutes an *impersonal* system based on political appointments and salaries, for the *personal* contact of the physician whose motive is sympathetic friendliness.

The attitude of the medical profession toward the plans of the "Foundations" has been expressed in three stages:

1. Passive aloofness.
2. Critical opposition.
3. Active preparation of a better plan.

Physicians generally have passed through the stage of *passive aloofness* toward the newer developments, and are now in the midst of the stage of *critical opposition* to the revolutionary system of state medicine and voluntary insurance proposed by the "Foundations". The Medical Societies of a few states have also entered upon the stage of an *active preparation of better plans* based upon an evolution of the time-honored methods of private practice in which there has always been some participation by the state, especially along economic lines. Medical leaders are now engaged in devising a system in which the physicians shall be supreme in all phases of the actual practice of medicine, while the state shall *participate* in supplying all other forms of relief to the sick.

BASIS OF CHANGE IN METHODS OF PRACTICE

Changes in the practice of medicine may come by the forcible implantation of an extensive new system; or by the development of a new method for each condition or need as it arises. Two lines of practice which the "Foundations", as well as physicians, consider to be in need of immediate extension are:

1. Preventive medicine to all classes of people.

2. The treatment of the sick poor.

The "Foundations" plan to meet these conditions by two revolutionary means:

1. Public clinics and health centers, with doctors giving free service.

2. Public physicians in the employ of the government.

THE NEW JERSEY METHOD OF EVOLUTION

New Jersey has undertaken pioneer work along the lines of both prevention and treatment. It has combatted the growing menace of health centers by taking the idea of the doctor's "Public Health Hour" from urban Detroit, and adapting it throughout the state, in rural as well as urban centers, with the result that the offices of an increasing number of physicians are "Health Centers" ready to give immunizations to all who seek them earnestly. The state will contribute to the work by supplying the material for producing the immunities.

The outstanding original contribution of The Medical Society of New Jersey toward the equitable distribution of medical services has been its Medical Advisory Committee to the State Emergency Relief Administration (the E. R. A.), which dealt with the problem of medical service to the poor. A system of medical organization was modeled after that of the government:

1. A state-wide committee or board.

2. A similar one in every county.

3. Every doctor to treat the poor patients who call him, but the government to pay the bill after it has been audited by the committee of the County Medical Society.

The New Jersey system has been in operation for only a year, but it is successful because its organization is a simple evolution of older methods of practice which are founded on the American system of personal initiative and co-operative effort.

The New Jersey plan of dealing with individual doctors in attaining one definite objective at a time is recommended to the consideration of the Medical Societies of other states and of the American Medical Association; and especially to those who seek to devise a complete system perfect in its theoretical details, but impractical in its application because of its wide extent, the complicated organization required, and the delay in establishing it.

Field Visits

Beginning in July the Executive Secretary will visit the chairmen and members of the committees in charge of the two projects now in operation throughout the state under the auspices of The Medical Society of New Jersey. Pressure of work in connection with legislation and other duties of the Society Executive has made field studies impossible at an earlier date. This delay has not been serious for there have been other obstacles occasioned by the many changes in procedure and policy of the E. R. A. during this period. The delay in obtaining free toxoid and vaccine from the State has held up the development of the "Public Health Hour" in the physicians' offices.

Fortunately, the hard work done by the chairmen and members of the E. R. A. Medical Relief, the Public Health, and Legislative Committees of the State Medical Society has finally borne fruit, and the further expansion of these Community Health Services is now up to the *individual members* of the component Medical Societies in each County.

The outcome of their efforts will prove (or disapprove) our belief that the physicians of this state can and *will* plan and *provide* community health services as the needs arise; that such services will be economical and effective.

LEROY A. WILKES,

Executive Secretary.

ORIGINAL ARTICLES

MEDICAL PROBLEMS IN NEW JERSEY

A STUDY OF CONTRACT PRACTICE AND DISPENSARY ABUSES

By THOMAS K. LEWIS, M.D., Camden, N. J.

The report of the Sub-Committee on Medical Practice of the Welfare Committee of The Medical Society of New Jersey, Thomas K. Lewis, Camden, Chairman; Anderson A. Lawton, Somerville; Chester I. Ulmer, Gibbstown; H. B. Wilson, Hackensack; E. LeRoy Wood, Newark.
Delivered at the first General Session of the 168th Annual Meeting of The Medical Society of New Jersey, June 5, 1934

The subject matter contained in this paper represents the results of investigations and deliberations carried on during the past winter by the Sub-Committee on Medical Practice—a subsection of the Welfare Committee of the Medical Society of New Jersey. At the outset of the year when this new Committee was created, our President, Dr. Quigley, requested that we concern ourselves chiefly with a consideration of contract practice and free dispensaries; and that we study the evils and abuses existing and suggest such remedial measures as might seem feasible. In this undertaking we determined to disregard or rather to unlearn much that we had assimilated from the great mass of literature that has appeared during the past few years from so many sources upon these vital subjects. Our attempt, in brief, was to survey the field as we should find it in our own state, draw, in so far as possible, independent conclusions, and recommend such salutary measures as might seem appropriate and practicable of application in our own Commonwealth.

STUDY ON DISPENSARY ABUSES

In approaching a study of dispensary abuses, a brief résumé of the history of the development of this institution will be of considerable benefit.

The earliest thing in the way of a dispensary appeared in England and Scotland several hundred years ago where charitably-minded physicians set aside certain hours for free treatment of the poor in their own offices or surgeries, as they were called in that day. In the middle of the last century, here and there began to appear organized clinics or dispen-

saries for treatment of the indigent, supported financially by the laity and technically by voluntary professional service. An example of this was the Camden City Dispensary, which had its origin shortly after the Civil War and continued to function actively up to the early part of the present century. It was not until the latter part of the 19th century that dispensaries began to make their appearance as an adjunct to the general hospital, which up to that time had cared only for the indigent bedfast patient. Coincident with the advent of this new department in the hospitals came the rapid development of the specialties which resulted in extensive departmentalization. Each new service created its own dispensary, which was jealously fostered as a feeding ground for the inside service. Large, well-run dispensaries redounded to the glory of the various services and offered a menas of ethical advertisement. The ensuing rapid growth of dispensary service caused the creation of many lay jobs, and as the importance of these new positions depended upon fat statistics, no efforts were spared to swell the attendance and perfect the efficiency of the dispensaries. Records became more elaborate, and complicated filing systems were installed until at the present time most institutions find it necessary to employ no inconsiderable force of specially trained clerks.

The *social service* originated by Richard Cabot in the Massachusetts General Hospital, for the very laudable purpose of assisting the dispensary physician in rendering his efforts fruitful by following dispensary patients into the homes and supervising the application of treatment ordered, was quickly approved. Within a few years it had been adopted by

practically every hospital in this country. Thus was a new child born. This service has changed much in recent years. Less and less does it render assistance to the physician. Very little home visiting is done. Rather, the effort made is to wet nurse the patients, to make dispensary treatment as smooth and felicitous as possible and to remove all sting from the fact of being a free patient. In addition, field workers connected with many other agencies bring their proteges into our free dispensaries literally by the thousands with little or no thought as to economic status. As a result of all these tendencies there has grown up in the public mind the feeling that the hospital dispensary is there for the use of any and all who choose to enter its welcoming portals. Half-hearted inquiry as to economic status is often received with indignation.

In addition to hospital dispensaries there have appeared from time to time in the larger communities certain lay controlled dispensaries and clinics fostered and financed by wealthy uplifters who are so emotionally enthusiastic about these, their pet charities, that they do not hesitate to solicit actively their patients in open competition with the doctor.

Quite recently health bureaus and school boards have entered the medical field with the establishment of various types of clinics, such as child welfare clinics, prenatal clinics, health camps, tuberculosis clinics, immunization clinics, etc. These state-run agencies make no effort toward economic segregation.

The result of the mushroom-like growth of these various institutions and agencies for free and semi-free treatment of increasing masses of our population is that the medical profession finds itself confronted with a rapidly diminishing field of legitimate endeavor. We are face to face with a clear-cut problem. Either we must act vigorously to curb this alarming growth of mass medical practice, or very shortly we shall be compelled to go all the way into some form of state medicine.

A rapid survey of the state which presumed to investigate only the larger representative hospitals and committees has been made by your Sub-Committee. While in a few isolated instances ideally managed dispensaries have

been discovered, upon the whole many abuses and evils have been predominately prevalent throughout the whole of our state. These can be summed up as follows:

1. Lack of proper and adequate investigation of the economic status of patients admitted for free treatment. (In some cases no investigation.)

2. Carte blanche to the proteges of school nurses, field workers of various organizations, social uplifters and influential employers without any investigation whatsoever.

3. The absence of any standard interpretation of the meaning of the word indigency.

4. An over-zealous social service that has departed from its original function of assisting the physician, and has assumed a paternalistic attitude toward applicants for treatment.

5. Medical service de luxe offered on a silver platter to the poor and semi-poor, so that a certain stratum of society has learned to prefer dispensary service to that offered in the office of private physicians.

6. The prevalence of the belief among the laity that dispensary service is available to anyone whether able to pay or not.

7. Lack of any effort at control of admission to fit the capacity or staff of the dispensaries.

8. Lack of mutual sympathetic understanding between the dispensary physicians and boards of managers resulting from the absence of official contact.

9. The development of many clinics as adjuncts to public health departments, such as baby saving clinics, prenatal clinics, immunization clinics and health camps. Because these agencies are provided for by public funds, no one is excluded.

10. There are a few instances of lay-controlled clinics that actively solicit patients in open competition with the medical profession.

Obviously reforms are necessary. Many of these reforms must begin with the physician himself. Patients must be taught by practical experience that just as adequate service can be obtained in the physician's office as in the hospital dispensary, and upon a much more personal and sympathetic basis. There is no reason for avoiding simple laboratory measures

such as urinalysis and blood counts in ordinary office practice. The physician should be ready at all times to administer prophylactic measures, such as diphtheria toxoid and smallpox vaccination. He should be prepared to give periodic health examinations and should show an active interest in all phases of preventive medicine. It should not be forgotten that our woeful neglect of these matters has had much to do with the establishment of the numerous clinics by health and school authorities and with the growth of diagnostic clinics and life extension services, so much in vogue.

An important step in the correction of existing evils is the reorganization and standardization of hospital dispensaries. The following dispensary plan has been agreed upon by the Sub-Committee on Medical Practice, and was presented to the House of Delegates on June fifth.

ORGANIZATION OF THE IDEAL DISPENSARY IN A NON-TEACHING INSTITUTION

1. The *purpose* of a free dispensary shall be to facilitate the treatment of indigent ambulant patients by having them appear at a definite time, convenient for the physicians donating their services.

2. *Control* of the dispensaries shall be vested in a staff committee of three members who are in constant (weekly or bi-weekly) contact with the dispensary committee of the governing body. Service on this committee shall be rotating in character. All dispensary policies and disciplinary measures shall pass through this committee. And if a medical director be appointed to manage the dispensary, he shall be directly under the control of the staff committee, and not the governing body.

3. In *financing* this department it must be recognized that the dispensary is a charity, and that it must be supported by charitable donations, the physician giving his time and the philanthropic individual his money. The costs of dispensary operation shall be carefully separated from the hospital account. Services rendered a dispensary patient in the hospital operating room, x-ray department, physio-therapy department, laboratory, etc., shall be charged against the dispensary.

4. The *personnel* of the well-organized dispensary shall consist of the following:

a. *Physicians*, who are qualified in their particular branch—or who are so training.

b. *Nurses*, staff and student, whose entire duty for the time is in the dispensary.

c. *Clerks*, trained in handling patients and records.

d. *Registrars*, who understand the various dispensaries and can elicit information from applicants for treatment.

e. *Social Service Workers*, who understand patients and who are sufficiently familiar with the treatments ordered to see that such treatments are carried out.

The object of all this personnel is to make the dispensary work easier for the physician, so that he may see a larger number of patients in the allotted time.

5. The *patient* eligible for dispensary treatment should be one who cannot afford adequate medical care. By this we mean a patient who does not have means to consult a physician in general practice and be cared for or directed by him. The charge to the patient for dispensary treatment should be nominal (certainly less than fifty cents). Requirement for admission, except for first treatment in emergencies, shall be a note from the family physician or responsible agency stating that the patient is worthy of free treatment. The enforcement of this rule immediately solves the problem of dispensary abuse by non-charity patients. This admission rule shall be enforced for each re-admission.

Here should be considered the patient of greatly restricted means in need of consultation advice, but unable to pay the standard fee of the specialist. Such individuals should not be referred to free dispensaries. Rather, our specialists should be encouraged to set up special hours in their own offices for examining such patients suitably referred by the family physician.

6. The *Social Service Department* shall be conducted for the purpose of making certain that the physician's instructions are carried out as he desires, and it shall serve no other purpose. It shall be directly under the control of the staff committee or the medical director.

7. The *Pharmacy* shall be adequately organized to compound and dispense the official drugs. Proprietary remedies and patent medicines shall be barred. All drugs shall be dispensed at cost for the patient who can afford to pay one-half to two dollars for prescriptions should not be a dispensary patient.

8. Extra departmental charges to dispensary patients for work done in x-ray, laboratory or physiotherapy departments shall be as close to the cost basis as possible.

9. The *admission clerk* shall be a tactful individual, preferably with business training, who interviews each applicant for treatment and directs him back to his family physician, to the private office of a staff member, or to the dispensary.

We are recommending that the above standard of dispensary set-up and management shall be adopted by the Medical Society of New Jersey, and that such plan or set-up shall be forwarded to all hospitals of the state urging its adoption. Further, it was recommended that the American Medical Association shall be urged to adopt a definite dispensary plan, and that the hospital committee of the American Medical Association be empowered, eventually, to insist upon adherence to such plan by all hospitals falling under its jurisdiction.

STUDY OF CONTRACT PRACTICE

Whether we approve of it in principle or not, contract practice is here as a permanent fixture. Many factors conspire in making its presence an unavoidable necessity. In a government that grows increasingly bureaucratic, the various state, county, and municipal medical positions, if conducted on a fee basis, would become cumbersome, unwieldy and inefficient. Red tape, shifting of responsibility and political interference would be increased. Without doubt many of these jobs can be more economically and efficiently handled on the contract basis. In the field of industry contract practice has come into being as a result of necessity. The Workman's Compensation Act while favorably effecting the laborer has put the employer "on the spot" and has forced him to protect himself by way of insurance. The insurance companies make certain de-

mands of the employer along the lines of medical care and protection. Also certain industries are of such a nature as to entail physical danger to the workmen to an extent that renders imperative the presence of immediately available medical aid. All these factors, briefly alluded to, render contract practice unavoidable and justifiable in industry. Such practice, properly regulated, need have no objectionable features and should result in mutual good to all parties involved. It remains for the medical profession to stand firmly for those principles which, when applied, will ensure satisfactory contract practice and thus adapt itself to a new phase of the practice of medicine.

These principles that will be productive of soundly ethical contract practice, are listed as follows:

1. The physician upon entering into a contract will have a detailed written agreement as to the duties, scope of activity and responsibilities of the position together with a clear understanding as to the limitation of his activities in order that he may not be called upon for unethical procedures.

2. The duties and the salary shall be such as to uphold the dignity of the profession and render worthwhile a high-grade type of medical care.

3. Competitive underbidding with other physicians should not be countenanced.

4. The details of the proposed contract should be discussed with and approved by the Board of Censors of the component county society.

5. Appointments of physicians to state or municipal positions should receive the approval of the State or County Medical Society concerned.

6. Broadly, the duties of the contract surgeon should be limited to:

- a. The examination of applicant for employment;

- b. The treatment of surgical and medical emergencies arising while the employee is on the property of or executing the orders of his employer;

- c. The supervision of such hygienic and sanitary measures as will contribute to the welfare of the employees; and,

d. Advisory capacity to the employer for determining whether medical or surgical care being administered to an employee by outside physicians is adequate.

7. Free choice of physician by the employee should in no way be interfered with except that the request for consultation should be permissible.

8. There should be no solicitation of patients.

9. There should be no competition in any way with the physician in general practice either by medical treatment of an employee beyond the immediate emergency or the treatment of any member of the employee's family.

It should be granted that much of this code may be waived in those cases where industry has caused the congregation of families at a point remote, geographically, from civilization.

Our state survey of Contract Practice has been somewhat sketchy. However, sufficient data has been accumulated to justify the belief that we have obtained a fairly comprehensive bird's-eye view of the field. We find the problem a rather intricate and complex one, with many situations difficult of analysis, which we will discuss in some detail.

Industrial Field. At least one example of contract practice at its worst has been reported, though complete information is lacking owing to the refusal of company officials to discuss the matter. The data available has been obtained from a physician formerly employed by this firm. It is the case of an industrially owned and controlled town which is closed to all physicians other than those employed by the company, except for the occasional use of consultants. This situation exists despite the fact that there are a number of nearby communities with an abundance of first class medical talent.

On the other hand, many of our large industrial plants throughout the state have a sane conception of contract practice and the medical activity in these establishments is above reproach.

The largest group of all is composed of those firms employing part-time or full-time contract physicians which, while in principle sound, yet in practice are constantly, to a

greater or less extent, stepping over the boundary line into illegitimate activities. Some of the irregularities encountered are as follows:

1. Treatment of colds, dyspepsias, and similar medical conditions, not merely in emergencies but for the full extent of the illness. Pills, capsules, or bottles of liquid medicine in sufficient quantity for a week's use, are dispensed with instructions to return for subsequent treatment.

2. In some of these plant dispensaries it has been reported that medicaments such as liniments, gargles, cough mixtures, cathartics, etc., are freely handed out for the use of other members of the families not employed in the establishments.

3. Through the agency of over-zealous officials and foremen there have been many cases where employees have been coaxed away from the family physician to be treated by the contract doctor or through advice by him, have been induced to consult other medical opinion.

4. There have been reported cases where a contract surgeon has arbitrarily assumed treatment of accident cases when injury has been sustained outside of the plant and treatment already instituted by a private physician.

5. Through fear of losing the job, many employees subject themselves to extended treatment of injury and disease when they would much prefer to consult an outside physician. In many cases this fear is ungrounded but there are some instances where such fears are insidiously and purposefully instilled.

Obviously many of these abuses are as much the fault of the contract physician as of the plant officials.

Rehabilitation clinics not only present a problem in a discussion of dispensary evils but also warrant study in the consideration of contract practice. The chief of this clinic is usually also advisor to the Department of Labor in the informal hearings of compensation cases. The salary of the combined jobs is insufficient for maintenance. The men occupying these positions are also found to be holding contracts with several industrial plants, with insurance companies and are also actively engaged in the treatment of compensation cases derived from various sources. With this mul-

tiplicity of contacts it is almost humanely impossible for them to function in their most important capacity—namely that of impartial medical judges. It would seem obvious that a salary sufficient to render these physicians independent of other entangling alliances might be most desirable.

School Medical Service. School medical service presents various problems which have a definite bearing upon contract practice. The duties of the school physician involve:

1. Annual examinations of all students in their district,
2. Administration of large numbers of antidiphtheretic treatments,
3. Regular periodic visits to the various schools,
4. Partial responsibility for control of epidemics,
5. Special examinations and inspections for medical emergencies and problem cases.

In view of the fact that each doctor has from one to two thousand children under his jurisdiction, this represents an enormous amount of effort for which the compensation is ridiculously low, with the result that the work is of necessity superficially executed and much of it is relegated to the school nurse, who actually in some cases has assumed the prerogatives of a licensed physician. While this large gesture at preventive medicine is being made, the hygiene of the school room is permitted to rest with the judgment of each individual teacher, often arbitrary as well as unsound.

The trend of school medical service has been gradually extending itself beyond its normal function, that of caring for the health of the *child in school* to the point of assuming responsibility for the health of the *school child*. This does not *tend toward* socialized medicine; it *is* socialized medicine. The care of each child should be an individual family matter, one for the parents to work out in conjunction with the advice of the family physician. This combination is best able to cope adequately with the problem. To deny this principle, even though there be individuals who shirk or are incompetent for the duties of parenthood, is to repudiate the family as the fundamental unit of our national social economy. To deny this

principle is synonymous with raising the red flag of Sovietism.

Our purpose is not to decry the efforts of the school physician, but to point out the impracticability of the task demanded of him. To examine a thousand or two children within a short period of time and be prohibited from removing any clothing, can never mean anything but a gesture, and, while undoubtedly many gross defects are discovered, it tends to develop a feeling of false security with the great mass. If this procedure is to be continued, why not remove the clothing restrictions, pay the school doctor adequately and give him a chance to do the job thoroughly?

Our recommendation is that the school medical service return to its original field, namely, that of the care of the child in school, inspection and control of hygienic and sanitary conditions, epidemiology, and the investigation of special problem cases. If annual examinations are demanded—and the idea is a splendid one—let such examinations be made by the family physician. Certificates of examination and diphtheria immunization could just as readily be made a requirement of admission to school as the certificate of vaccination against smallpox, which is already a requisite for admission in many parts of the state. The following is a tabulation of the suggested activities of an ideal school medical service:

1. Supervision of hygienic measures such as regulation of heat and ventilation of the school rooms, regulation of exercise (with and without change of clothes) and the control of food served in the lunch room.
2. Sanitation of the school buildings and grounds.
3. Regular periodic appointments with each room teacher for the consideration of problem cases.
4. Coöperation with the family physician in the study, care and regulation of activity in physically defective children—such as cardiac cases, hyperthyroidism, asthmatics, malnutrition cases, anemias, etc.
5. Supervision of and coöperation with the activities of school nurses.
6. Regular conference of the school physician with the school heads and the boards of

education, for the effective coördination of all of these various activities with school routine.

Other State and Municipal Contract Positions. City physicians, county physicians, resident physicians in our various institutions and other public positions present many minor problems too numerous to dwell upon in detail. The one outstanding and glaring fault is the ridiculously low level of remuneration both in proportion to the amount of professional activity required and in proportion to the importance of the position held. With state medicine as an imminent possibility just over the horizon, one wonders what to expect when legislators and politicians have found the cost of medical labor so cheap.

Some of our societies have advocated censorship of contracts and punitive measures for those physicians involved in unethical alliances. At the present time we feel that such action is inadvisable. Many of our physicians are holding inadequately paid positions, but because of the present economic emergency, the loss of even these small salaries would, in many cases, entail great hardship. Further, with such a large number of our reputable members in good standing holding school jobs, municipal and state positions which violate many principles of ethical contract practice, it ill behooves us to assume too critical an attitude toward those physicians practicing contract medicine in industry. Faced with this dilemma, we would recommend for the immediate future that the Medical Society of New Jersey embark upon the following activities:

1. The adoption of a code for standardization and regulation of contract practice.

2. The instruction of our members, particularly the younger men, in the ideals of ethical practice, and the encouragement of our members to consult with and accept the advice of the Boards of Censors of the respective component societies when contemplating the acceptance of any contract position.

3. The institution of a campaign for modification of school medical service, either toward limitation of present activities, or for their more thorough execution.

4. That a concerted and sustained effort be made to remove state and municipal medical positions from political control, and to procure for these positions adequate remuneration.

The difficult situation in which the medical profession finds itself at present has not come into being in a day, but has developed gradually over a period of many years as the result of a multiplicity of factors. By prodigal and often unwise free contribution of his services and by slothful indifference to obvious abuses insidiously creeping in during prosperous years, the doctor has contributed largely to his own deplorable present-day condition. Now, when the shoe pinches in these lean years of economic depression, existing evils can not be corrected abruptly or radically either by arbitrary action on the part of organized medicine or by legislation; nor can corrective measures be based upon the supposition of a social fabric such as that which existed in the decade preceding this economic debacle. Society is moving ponderously toward a new economic order. What that new order will be only the future can disclose. The medical profession must fit itself into this metamorphizing social structure not only with protective self-interest in view but with a sympathetic regard for public welfare if it hopes to avoid governmental intervention. At the moment, the rabid extremist in our ranks is as great a menace to our cause as is the inactive reactionary who deludes himself with a hope for return of the good old days. Neither lamentations of misery nor dreams of a millennium ever won any victories.

That the recommendations for action proposed by your Sub-Committee on Medical Practice are neither ultra radical nor aggressively militant we freely admit. Justification of our conservatism rests in the fact that, provided the recommended activities are approved and vigorously carried on by the Medical Society of New Jersey, they will not only serve as an entering wedge in this process of readjustment, but also will carry the certainty, to some extent, of gaining immediately effective results.

ANESTHESIA FROM A SURGEON'S VIEWPOINT

By MAX DANZIS, M.D., F.A.C.S., Newark, N. J.

From the Surgical Service, Newark Beth Israel Hospital. Read before the Surgical Section, Academy of Medicine of Northern New Jersey, December 28, 1933.

This paper is undertaken for the sole purpose of presenting before you some facts and conclusions gathered from a large number of surgical operations performed under various forms of anesthesia, such as ether, spinal, avertin, or a combination of methods. It is not my intention to advocate one definite anesthetic procedure, to be adopted to all types of patients. I firmly believe that there are definite indications and contra-indications for certain types of anesthetics, which can only be decided upon after consultation between the surgeon and a trained anesthetist. The choice of any particular form of anesthesia should not be made independently, either by the surgeon or the anesthetist. Experience has shown that best results can only be obtained by careful and intelligent coöperation between the two.

Like many other surgical controversial subjects, spinal anesthesia came in recently for a great deal of condemnation on one hand, and very much enthusiastic and exaggerated praise on the other. One report starts out with this statement: that "spinal anesthesia¹ is responsible for more deaths than any other anesthetic in proportion to the number administered (one death to 120); that the mortality from spinal anesthesia is exceedingly high, particularly for the beginner".

In visiting a teaching clinic recently, we were told that spinal anesthesia is not used because two patients developed respiratory paralysis, and for that reason the method was entirely condemned. At the same time the patient who was being operated that morning would have, in my opinion, fared much better under spinal anesthesia, on account of a marked distension which was present as a result of a slow obstruction due to an intestinal growth. This marked distension would have been considerably reduced under spinal anesthesia, and the operation would have proceeded much more satisfactorily.

Criticisms directed against this method are frequently heard which are not based on definite clinical facts. Many postoperative deaths are contributed to spinal anesthesia which, upon careful analysis, would be found to be due to some other cause. Some of the antagonism to this method is frequently based upon one or two unpleasant experiences. Then, again, there are some who have never used it, but persist in condemning it as a dangerous method, although their opposition is purely based on hear-say evidence.

In reading over the voluminous literature written upon this subject, one will find that most of the discouraging reports came from sources where the anesthesia is not concentrated into a distinct department in care of a trained medical anesthetist. The best results are reported from sources where the anesthesia is carefully supervised and administered by expert anesthetists who have received careful training in the various methods of its administration.

On the other hand, we find much enthusiastic praise and favorable conclusions regarding spinal anesthetics drawn from a large series of cases by various authors. From a comparative statistical report of 2000 ether and 2000 spinal anesthetics, the authors draw the following conclusions:² (a) "Deaths in the operating room, as has frequently been alleged, are by no means more frequent with spinal anesthesia than with ether. In fact, in this series they were far more commoner with ether. (b) Postoperative deaths occurring in the first few days following operation are not, as is frequently claimed, more common after spinal anesthesia; the reverse was true. (c) There is not a noteworthy increase in the incidence of pulmonary deaths in spinal over those occurring following the administration of ether. (d) Spinal anesthesia can be used more or less as a routine measure in operations below the diaphragm, with far greater relative safety

than most surgeons at present seem to believe." Labat reports 1000 cases of spinal anesthetics with no deaths. Recently there were several other large series of cases reported, varying between 5000 by McCormack and 2000 by Gosset and Munod, in which no deaths occurred.

ANESTHESIA DEPARTMENT

Before proceeding with the discussion of my personal experience with the relative merits of the various anesthetic methods, I wish to emphasize strongly the importance of a well-functioning anesthesia department in a general hospital, in order that it may provide satisfactory anesthetics for the various types of operations, according to their indications; and also for the purpose of training the house staff in the various modern anesthetic methods. Without such a department, very little latitude is allowed to the surgeon in the choice of anesthetics. It must necessarily be confined to one or two limited procedures; consequently the patient is frequently fitted to the anesthetic instead of adapting the anesthesia to the patient.

We are very fortunate in having developed at the Newark Beth Israel Hospital a very efficient anesthesia department under the direction and personal supervision of a trained medical anesthetist specializing in that work only. We have adopted a method of close coöperation between him and the surgeon, and my personal experience with this method over a period of ten years has been highly satisfactory. During these years we have had many occasions to discuss the choice of anesthesia in certain types of cases where the risk was very grave—no matter what method was adopted—and we found that the patient always benefited by such a procedure. It was found that in certain types of cases where the operative risk was very grave it was not fair to place the entire responsibility on the anesthetist, though he may be willing to assume it. The surgeon must, therefore, be willing to forego some of the refinements of technic or anesthetic perfection, or personal comfort, in order to obtain favorable anesthetic results. We have not attained perfection. In spite of all these precautions and anesthetic skill, there were several deaths in the last ten years, both

in the general and spinal anesthesia groups. Personally, I was extremely fortunate in having escaped such an experience, but during that period I had ample opportunity to observe the operative and immediate postoperative effects of the various types of anesthetics, particularly the spinal.

SPINAL ANESTHESIA

My own experience with that method, while at times a little exciting, particularly in the early days, has been generally very favorable. I know of no more effective anesthesia than this in low abdominal, pelvic, rectal and vaginal operations, such as perineorrhaphies, hysterectomies, rectal resections, etc. It is the ideal method in abdominal conditions associated with intestinal distension, whether the result of an acute inflammatory condition or chronic or acute intestinal obstruction. It is a method par excellence in amputations of the lower extremity, particularly when associated with metabolic or organic disease, such as diabetes, endocarditis, etc. The immediate postoperative effects are by far less unpleasant in these types of operations than those of general anesthesia.

It is not essential for the purpose of comparative analysis to review thousands of operations performed by us since this system was inaugurated. I believe a lesser number would suffice to bring out the salient points. We have, therefore, selected for the purpose of comparative study 210 cases picked at random from the 1933 files of our operative records without any regard either to time-sequence, age, type of operation or any other criteria. These 210 operations, performed by me, included in this group, consisted of 100 spinal anesthetics (50 pantocaines and 50 novocaines), 100 general anesthetics (gas, oxygen, ether), and 10 in which we used avertin alone or augmented by either a local or general anesthetic. The ages in the general anesthesia group ranged from $3\frac{1}{2}$ to 73, the average being 31. Of these 100 cases, 82 were abdominal operations of various types, such as hysterectomies, cholecystectomies, appendectomies, gastro-enterostomies, etc. The remaining 18 were more or less of minor types.

TABLE I

Spinal	100
General (gas, oxygen, ether)	100
Avertin, supplemented by local or gas, oxygen, ether	10
Total number of cases	210
Spinal	
With novocaine	50
With pantocaine	50

TABLE II—AGES

	Years
General Anesthesia—	
Youngest	3½
Oldest	73
Average age	31
Spinal Anesthesia—	
Youngest	13
Oldest	75
Average age	42
Avertin Anesthesia—	
Youngest	7
Oldest	63
Average age	37

In the spinal anesthesia group the youngest was 13 and the oldest, 75. The average age was 42. In this group the total number of major operations was 85, of which 80 were abdominal and 5 were mid-thigh amputations for diabetic and embolic gangrene. The other 15 cases were also extra-abdominal operations.

In the avertin and combination groups the average age was 37; the youngest was 17 and the oldest, 63. The operations included in this small group were hysterectomies, cholecystectomies, and several thyroidectomies. Most excellent results can be obtained by the combination of avertin; and, if necessary, augmented either by general or local anesthesia in the thyroidectomy operation. There is a double advantage in the use of the novocaine infiltration in the latter type of operation, since it obviates cerebral stimulation from the field of operation during the primary incision, and it facilitates skin cleavage. It is an excellent method for obviating the psychic trauma in very apprehensive and nervous children, during the pre-operative stage, especially when the child has to undergo some form of secondary operation. It also has a distinct advantage in head surgery, since the anesthetic effect lasts about two hours. The only disadvantage to its use is the duration of the postoperative narcosis.

There was no death in both groups of this series, either on the operating table or during

the postoperative course, that may be attributed to the anesthesia. There were three postoperative deaths in the general anesthesia group within a week following operation; but death in every one of these cases was due to peritonitis, which was the result of the pathological condition found at the operation, such as peri-gastric abscess and carcinoma of the liver.

There were nine postoperative deaths in the spinal anesthesia group, or nine per cent—a high postoperative mortality, at first glance; but upon further analysis we find that the operative findings justify this mortality. Four died within a period of one to six weeks following operations for advanced visceral carcinoma of stomach, rectum, etc. Three died following mid-thigh operation for gangrene, two of which were the result of diabetes and one following an unrecognized femoral embolism which caused complete obstruction of the vessels of the leg and thigh, with superimposed gas-gangrene. The average age of these three patients was 70. One patient died following operation for obstructive jaundice of long duration due to a stone in the common duct, upon whom a cholecoduodenostomy was performed. This patient died several days after operation, from what we commonly designate for want of a better term as "liver shock". One patient died following operation for diverticulitis and peri-diverticulitis of the sigmoid. One fact stands out most prominently in our analysis of this postoperative mortality, i. e., that all these patients were very poor operative risks and the administration of a general anesthetic was deemed inadvisable because of that. This is also true of a number of other cases which are included in this spinal anesthesia group. Despite that fact, our immediate postoperative anesthetic results were not in any way affected by the adoption of this method. It is fair to assume that some of the postoperative sequelae would have been much more aggravated, or their incidence more frequent, if a general anesthetic had been employed.

Spinal anesthesia is very frequently blamed for many postoperative complications, beginning with headaches and ending with fecal impactions. Most of these complications may be explained on some other grounds. Some may

be the result of ordinary surgical trauma which cannot be entirely obviated. Others may be the result of a prolonged operation or due to some special technic or poor surgical technic. There are a few postoperative complications that are characteristic of spinal anesthesia which are more or less annoying but not more so than in any other forms of anesthesia. They all have their usual postoperative unpleasant sequellae. What is more unpleasant than the acute bronchial irritation and the pulmonary congestion or the prolonged nausea and vomiting associated with the administration of ether—the safest of all anesthetics? The prolonged narcosis following the avertin, or the intravenous administration of sodium-amytal, are not altogether too pleasant sequellae for the patient or surgeon. Most of these complications are transitory, and so are most of the postoperative sequellae of spinal anesthesia, with the exception of some rare neurological complications; and even these can be offset by the very serious and not uncommon pulmonary complications, such as lung abscess, that may follow inhalation anesthesia.

PROGRESS NOTES

I have made a careful study of the progress and nurses' notes of all our charts included in this series for the purpose of establishing the relative prevalence of certain types of postoperative complications in the various types of anesthetics, with the following result:

Headaches—This was a rather frequent complication during the early days of spinal anesthesia, but its incidence has been progressively diminishing. It is far less common now than formerly. This is most likely due to a more perfected technic of administration. In our series of 100 spinal anesthetics we have a record of three cases of persistent headaches lasting for several days after the operation which may be directly charged to this form of anesthesia. In the general anesthesia group we also have three cases of persistent headaches, the cause of which was only known in one but not explained in the other two, but since the headaches came on several days after the operation they could not be attributed to the general anesthesia.

Nausea and Vomiting—It is hardly necessary to discuss the comparative prevalence of nausea and vomiting in the two types of anesthetics since it is well known that it is rather common in both types. It is apt to be less common in the spinal types. In most of our novocaine anesthetics, nausea and vomiting took place about fifteen minutes after the administration of the anesthetic. It varied in different types of individuals. It is apt to be more persistent in the apprehensive and nervous type patient, coming on spasmodically throughout the operation. It is more likely to take place during upper abdominal explorations when operating upon the gall-bladder or stomach and when undue traction is made upon the mesenteric attachments. It is less likely to occur when working in the pelvic region or during vaginal operations. It is less apt to occur with pantocaine than with novocaine.

Gastric and Intestinal Dilatation—A frequent cause for criticism of spinal anesthesia is that it is apt to induce gastric dilatation or general abdominal distension. My own experience is not in agreement with this statement. In 100 spinal anesthetics we find only one case of gastric dilatation, and this was due to generalized peritonitis following operation for an old infected ovarian cyst and cannot be attributed to spinal anesthesia.

There were twelve cases of postoperative general abdominal distension. In four, the distension was of a very moderate degree, lasting only twenty-four hours. All four were abdominal operations and the distension may be attributed to the usual operative trauma. Of the remaining eight cases, where the distension was very pronounced, we find that in five it was due to a generalized peritonitis following acute intra-abdominal infections, such as appendicitis, diverticulitis, ovarian abscess, etc. In the sixth case there is a preoperative neurological history, with general visceroptosis and atony, which probably were the contributing causes of the distension. The seventh case is that of a man seventy years old who had a mid-thigh amputation for thrombo-angiitis obliterans. He was bedridden for several weeks before the operation. The distension in his case was not very marked and disappeared

soon after operation. This leaves us only one case of marked abdominal distension, which the cause is debatable and may be attributed by some to the spinal anesthesia.

In the 100 cases which were operated under general anesthesia we also find one case of gastric dilatation which followed a cholecystectomy operation secondary to a previous cholecystostomy done three years previously, which was followed by a persistent biliary fistula, the result of a stone left in the gall-bladder. This patient developed a general peritonitis following operation, associated with marked urinary suppression, averaging only a 14 ounce output from the day of the operation until his death six days later. The gastric dilatation persisted in spite of a continuous siphonage through a Levine tube. Death was due to general peritonitis.

There were ten cases of general abdominal distension. In five, no distinct cause for the distension could be found in the local abdominal condition, unless it is explained by the usual surgical trauma. In the remaining five cases the distension was associated with other complications. In two, it was due to peritonitis; in one it followed an infection in the abdominal wall, and in two it was associated with pulmonary complications. In other words, the incidence of postoperative abdominal and gastric distension is about equal in both groups of cases. There are, however, five cases in this group in which the distension cannot be explained by the local abdominal conditions. One would, therefore, be apt to include that general abdominal distension is more likely to be present following the administration of general anesthesia than in the spinal types.

Pulmonary Complications—The etiology of atelectasis or massive pulmonary collapse, broncho-pneumonia and pulmonary embolism—three very serious postoperative complications—has been a controversial subject. Some claim that this complication is apt to be more common with the administration of general anesthesia, and others bring forward statistics to prove that it is just as prevalent, and more so, with the administration of spinal anesthesia. In looking over the list of pulmonary complications in this series we find that out

of 100 cases operated under general anesthesia there were two cases of atelectasis following cholecystectomy operation. In one case the x-ray showed "lobulated atelectasis on the right side, with congestion of the left lobe". The second case showed marked dulness in the right base. Both of these cases cleared up rapidly under CO₂ inhalation. There was no definite instance of broncho-pneumonia in this group of cases. One patient developed pulmonary embolism three days following operation for cholelithiasis and pancreatic cyst. Four other cases in this group showed distinct evidence of pulmonary complications immediately following operation of a mild type, such as disseminated moist râles, productive cough, etc. In one case a distinct pulmonary edema lasted for several hours, which cleared up under stimulation.

We failed to find any definite case of atelectasis, broncho-pneumonia or embolism in the spinal anesthesia group. There may have been very mild cases of temporary exacerbations of old chronic pulmonary conditions but evidently they were not sufficiently serious to draw our attention to them. Bearing in mind the fact that in quite a number of our spinal anesthetics—one of the indications for the use of that method—were chronic respiratory affections such as asthma or bronchitis, we should expect the incidence of postoperative pulmonary complications to be higher than in the general anesthesia group; but our experience is quite contrary to that.

From this comparative analysis of the postoperative sequelae in the two respective groups and from a general observation gathered from a large group of cases over a period of ten years one is justified in arriving at the conclusion that some of the post-anesthetic sequelae are apt to be less unpleasant and, certainly, not more prevalent in the spinal than in the general anesthesia group.

Sudden Death—The most common cause of sudden death in spinal anesthesia is probably due to an incorrect estimation of the patient's ability to withstand the operative shock. Some of these patients would probably die under some other form of anesthesia. The patient, suffering from an advanced myocardial dis-

ease with a badly dilated heart and a very low blood pressure, or one who is moribund or profoundly shocked should not be given a spinal anesthesia. I have on several occasions advised against its administration, although the anesthetist was willing to assume the responsibility—substituting local infiltration or reginal anesthesia instead. It did not change the operative outcome, but at least the death could not be attributed to the spinal anesthesia. I believe that with a more perfected technic these sudden deaths will be considerably reduced.

I believe that the choice of anesthesia should be made: (1) For its efficiency in inducing a smooth and effective anesthesia, free from any unpleasant effects upon the patient during its induction stage. Its effect should be even and durable, in accordance with the type and the duration of the operation. (2) It should produce sufficient muscular relaxation required for the performance of a certain type of operation, thus obviating any undue traction with its consequent surgical trauma. (3) When other co-existing constitutional disturbances are present, one should choose that type of anesthesia which is least liable to aggravate an already existing physical deficiency. It should be free from any delayed or prolonged toxic effects and be conducive to as few post-anesthetic complications as possible. And, above all, the anesthetist's experience in the administration of the various types of anesthetics should also be taken into consideration before the final choice is made.

IN CONCLUSION

I wish to repeat again that I am not advocating any particular type of anesthesia to the exclusion of all others. Only enthusiastic zeal-

ots will do that. I am convinced, however, that much better results are obtained with the newer methods of anesthesia through a well-organized special department of anesthesia in charge of a trained physician anesthetist.

We know that it is a very common practice to employ nurse anesthetists at a small salary who administer anesthetics to private patients; and the fees are collected and turned over to the hospital fund. In most cases the anesthetics are effectively administered, provided it is confined to a particular method, such as gas, oxygen, ether or ethylene; but when the scope of the anesthesia is a bit widened and more latitude in the choice of various methods is demanded, it is absolutely necessary that a trained physician anesthetist be employed.

I believe that anesthesia is a very important branch of general surgery. The patient is as much entitled to the services of a trained medical anesthetists as he is to the services of a well-trained surgeon. Regardless of its economic value to the medical profession, which should be considered, we are also aware that all the recent advances in that field were made through the painstaking efforts of physician anesthetists; and, as such, it justly belongs to the domain of the doctor. Just as every well-organized hospital has a well-equipped laboratory in charge of a director of laboratories, and an x-ray department in charge of the physician roentgenologist, so every hospital should have a well-organized anesthesia department in charge of a trained medical anesthetist.

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DISEASE OF THE CORONARY ARTERIES

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Read by invitation before the Medical Society of New Jersey at its Annual Meeting at Atlantic City
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Everywhere heart disease has leaped to the top of the list of causes of death. In part this is due to a decline in mortality from tuberculosis, and in part to an actual increase in deaths from heart disease. At first sight (and to many who have not carefully studied the mortality statistics) this increase might seem disquieting. In reality it represents in large measure a triumph of preventive medicine. Young adults are escaping the ravages of tuberculosis and of occupational diseases, and are now living to the age period beyond forty when heart disease, vascular degeneration, and cancer prevail. By the prolongation of the average span of life, to 59 years as it now is, more individuals are kept alive to die in the higher age groups from those diseases that afflict advancing years. If there are relatively more people living now aged 60 and over than a half century ago, more people of that age will die; and they die largely from cardiovascular disease, Bright's disease, or cancer.

Dr. Dublin of the Metropolitan Life Insurance Company, Dr. Louis Lehrfield of the Department of Health of Philadelphia, and Dr. J. L. Mahaffey, Commissioner of Health of New Jersey, have kindly supplied me with data which demonstrate these facts clearly.

The tables I have gathered from various sources are so concordant that one must conclude there is an actual and not merely a relative increase in deaths from heart disease. This is shown in the figures from the State of New Jersey:

DEATH RATES PER 100,000 POPULATION
TABLE I

Age Periods	1922	1932
30 to 39	8	10
40 to 49	13	19
50 to 59	24	38
60 to 69	39	56
70 to 79	41	62
80 to 89	21	30
90 and over	2	5

It should be borne in mind in considering these figures that the rates are based upon total population and that the percentage of the population in the given age groups for 1932 may vary considerably from the percentage for 1922.

Whether there is, or there is not, an "alarming increase" in deaths from heart disease, the fact is that heart disease stands at the head of the list. This makes it a definite problem in health conservation in the sense that efforts should be made to postpone as late as possible death from those degenerative diseases among which that of the heart and blood vessels is the most important. Degeneration is the price of old age and mankind prefers to pay that price as late as possible. From a detached biologic point of view this may not be a desirable aim, an old tree bearing no fruit or only a few green leaves had better give place to a younger one, but society today with its humane instincts seeks to keep alive the cripple as well as the lean and slippered pantaloons.

CORONARY OCCLUSION

We shall not go into the history of coronary occlusion. Nearly everyone who writes exhaustively on the subject finds as he proceeds an earlier reference than his literary predecessors. We believe, however, that we have discovered the earliest reference to this condition—and yet some future writer may find still an earlier one. In Homer's *Odyssey* (The *Odyssey* of Homer, translated by T. E. Shaw, New York, 1932, p. 36), it is stated that Phoebus Appollo shed down his gentle darts upon Phrontis, son of Onetor, Menelaus' navigator, and "he dropped dead with the steering oar of the moving ship within his hands." This impresses me as an instantaneous painless coronary death.

CAUSES

Not much time need be given to consideration of the causes of coronary occlusion for the simple reason that we know so little about them. We can say under what conditions coronary disease may occur; but that is far removed from explaining its etiology. *Coronary disease* particularly coronary thrombosis, prefers the male sex between the ages of 50 and 70, although it may occur as early as 20 or 30. H. L. Smith and E. C. Bartels, (Mayo Clinics, XXIII, 1921, 612), report two cases and collect 20 from the literature in the age group 12 to 40 years. *Coronary occlusion* is more common in private than in charity hospital practice, indicating that social status is a factor. High blood pressure is an important element, but typical cases occur also in persons with low blood pressure. *Syphilis*, strange to say, is not significant in the etiology. I base this statement on my personal experience as well as on a study of the literature. *Syphilis* is important only when it produces atresia of the coronary ostia by extension from the aorta. Diabetes is by many considered an etiologic factor (Nathanson, Am. Jour. Med. Sc., April 1932, p. 495) although in my own series it does not appear to play a very conspicuous rôle. *Nephritis*, *thromboangiitis obliterans*, and *polycythemia rubra*, bear a relation to coronary occlusion. An embolus derived from a mural thrombus or rarely from a diseased valve may also cause occlusion.

That *polycythemia* through inspissation of the blood, may favor coronary thrombosis is theoretically possible and has been shown in one of our cases.

That *infectious diseases* in earlier life may play a rôle is a possibility that needs more investigation than it has received.

Heredity stands out prominently in any extensive study of coronary disease; it was present in 27 per cent of my own cases.

Regarding *habits*, I believe that the habit of worrying is one of the most effective in producing the coronary syndrome; overeating, overindulgence in sexual relations, especially if these are not accompanied by complete gratification, over-ambitiousness, also are prominent in the histories of coronary cases

if we but search for them. The *alcoholic habit* of itself, if not a by-product of the others mentioned, does not seem to me to lead to coronary disease. I cannot give the same clean bill of health to *tobacco*. One fourth of the patients with coronary occlusion that I have seen were heavy smokers. Here again it must be admitted that not all who smoke to excess become victims of coronary disease but the number that do is sufficiently large to make me rank tobacco definitely among the causes.

There is no physical or bodily habitus characteristic of patients destined to have coronary disease or coronary occlusion. Perhaps the stocky, short-necked, overweight, hypertensive individual predominates, but the slender and spare are not exempt. Many have tortuous temporals and arcus or annulus senilis. The radial arteries may be soft but in many instances they are thick and leathery, not beaded. The majority of "coronary" individuals are active and atheletic, often passionate golf players, but the disease, as I have said, occurs among the sedentary as well. The greater proportion are heavy eaters. Many are given to liberal night suppers, and the excessive use of tobacco is a habit common to a large number.

Since coronary anastomoses are richer in persons of advanced age, individuals over 70 rarely die of coronary occlusion (A. R. Barnes, Mayo Clinic, XXIII, 1923, 609).

SYMPTOMATOLOGY

The symptoms of acute sudden closure of a coronary artery of considerable size are dramatic in the extreme. The patient, usually a man past fifty years, of florid complexion, thick necked and heavy-set, is seized suddenly with an unendurable pain, in its fearful severity unlike anything he has ever experienced before. His face becomes ashen or bluish-gray, exsanguined, and pinched. A cold sweat breaks out over his body, the extremities become cold, the pulse small, thready and rapid, although sometimes it is slow. In certain cases no pulse is obtainable. The patient is apprehensive to the highest degree; he is sure death is in the offing. He may lose consciousness and may have a convulsion. The

heart sounds are feeble, the first sound at the apex scarcely audible; frequently a systolic murmur not heard before is found at the mitral area or over the body of the heart. Respiration is shallow and restricted; there may be shortness of breath and air hunger; sometimes the breathing is of the Cheyne-Stokes type. Râles may be heard over the bases of the lungs; sometimes pulmonary infarction occurs with spitting of blood. The blood pressure usually drops precipitously, sometimes to a point when none is obtainable by the auscultatory method. We have seen it fall from 220 to 90 systolic in the course of a few hours in a patient who nevertheless recovered.

The pain is of a crushing, crunching or tearing character and is situated usually behind the middle or lower sternum, or in the precordia in the region of the parasternal lines on both sides of the chest, or in the epigastrium, and even in the umbilical region. It is as a rule stationary but it may radiate into one or both arms, to the lower cervical region in the back or up into the jaws. In several of my cases the pain in the left elbow was more severe than the substernal pain.

The attack may be accompanied by vomiting and marked abdominal distention so that it closely resembles an acute abdominal catastrophe, such as perforation of a peptic ulcer, biliary colic, acute pancreatitis, mesenteric thrombosis, or the gastric crises of tabes.

As the outstanding features are those of shock, the temperature is low in the beginning, but it soon starts to rise to 100 or higher, rarely above 103. This is probably a protein fever caused by the absorption of degradation products from the infarction in the heart. To the same cause is to be ascribed the leukocytosis that appears soon after the onset of the thrombosis.

Coronary occlusion may cause instant death without any preliminary pain. Such apparently painless deaths are not uncommon on the golf links and in other public places. Sometimes if the patient has had a little bloating and belching of gas before, the death is attributed, at least in the newspapers, to acute indigestion. It is of course impossible when confronted with an instantaneous death to be

sure, before the autopsy, of what has actually taken place—whether there is a coronary obstruction, or whether death was due to angina pectoris without obstruction. This goes to show how closely the two conditions, coronary thrombosis and angina pectoris, are allied.

Psychic disturbances are not rare in the severer types of coronary occlusion. They may take the form of confusional states of hallucinosis, of delusions, of acute maniacal outbursts and of attacks resembling delirium tremens. In every case we have seen in which the patient survived the coronary occlusion, the psychosis disappeared completely.

LARVAL CORONARY DISEASE

In addition to the acute coronary closure with its tragic consequences there is a form of coronary disease which does not present a very striking picture. For that reason it is often overlooked. Anatomically it consists of a gradual narrowing of the coronary vessels due to a progressive endarteritis. The result is a lessening of the blood supply with a consequential oxygen deprivation of the tissues, a condition that I have called *histanoxia*. This *histanoxia* may lead to degenerative changes in the muscle fibers and their replacement by fibrous tissue. Clinically it may manifest itself in various ways. One is the usual type of chronic congestive heart failure. The other is more specifically coronary and gives a sense of substernal oppression which may pass into a definite pain on effort, and is relieved by rest. As there is at times some belching with the attacks, patients as well as physicians often interpret them as due to indigestion, an error from which there is not rarely a sad awakening, not for the patient, but for the doctor. Attacks of fainting may be produced by this chronic coronary artery disease. And then there are sudden types of heart failure approaching fainting, with pallor, sweating and great restlessness, but with absence of pain.

Acute pulmonary edema with inky cyanosis may be a manifestation of coronary disease. While I am speaking of this, I may say that in its suddenness and violence it tests the doc-

tor's resourcefulness and intelligence. The best measures for combating it are venesection, morphine and atropine, and if need be, dry cupping over the chest.

The earlier we can see patients with coronary disease, the better; and when we do see them, we must recognize the true condition and not be misled by the prominence of gastric symptoms. It is in the early stages that much can be done and the catastrophe of sudden occlusion either obviated or postponed to a late period when life no longer is very important. In any patient past fifty an unaccustomed, uncomfortable feeling behind the sternum coming on during walking or on any physical effort should awaken a suspicion of some cardiac abnormality. True, nothing may be discovered on

stereotyped and presents perhaps but one controversial feature and that is the use or the non-use of digitalis. We shall refer to this in a moment. The following is an epitome of the treatment of the attack:

Absolute rest, the most absolute, mental and physical, conceivable. It may be inadvisable to undress the patient at the outset. He should have no company and should not be allowed to talk. He should of course use the bed pan and urinal and should have a night and a day nurse when the circumstances permit. External heat should be applied.

For the relief of pain nothing compares with morphine in large doses. When morphine fails hardly anything else is likely to be successful, although in two instances one of us

TABLE II—DIFFERENTIAL DIAGNOSIS

	ANGINA PECTORIS	CORONARY THROMBOSIS
Beginning of attack	During effort	During rest
Seat of pain	Behind middle of sternum	Behind lower sternum or in the epigastrium
Radiation	To left shoulder and down left arm	May be absent
Dyspnea	Not present	Marked
Behavior of patient	Quiet	May be restless
Duration of attack	A few minutes	Hours to days
Shock	Absent	Present
Vomiting	Rare	Frequent
Pulse	Unchanged or tense	Small, often rapid
Arrhythmia	Rare	In about 15 per cent
Temperature	Normal	Elevated
Blood pressure	Unchanged, or rises	Falls, or remains stationary
Heart sounds	Normal	Frequently soft; pericardial friction often present; at times gallop rhythm.
Congestive signs	Absent	Often present
Electrocardiogram	Often normal	Usually characteristic
Nitrites	Useful	No effect

physical examination, though there is often a slight enlargement to the left, a snappy second aortic sound or a systolic murmur at the aortic area. An elevated blood pressure helps in directing the medical mind in the proper channel. The electrocardiogram may show some abnormality, a change in the Q or in the T wave. But the experienced and careful clinician does not need that; he reads the writing in the patient.

TREATMENT

Treatment divides itself into two parts, treatment of the attack and subsequent treatment. That of the attack is more or less

(R.) has applied leeches to the precordia and found that the pain immediately abated. Nitroglycerin is contraindicated, and yet patients sometimes take it because they have been in the habit of using it for attacks of angina pectoris. If the heart should stop suddenly and the doctor is at the bedside, he might resort to an intracardiac injection of 1 cc. of adrenalin chlorid 1:1000 solution. Under ordinary circumstances adrenalin and probably ephedrine are contraindicated in patients with angina pectoris and coronary occlusion.

Another agent of value in my experience is glucose or sugar. The glucose can be given intravenously. We have been in the habit of or-

dering gingerale, water-ice, apple sauce, pineapple juice, and orange juice for the purpose both of supplying fluid and of supplying sugar.

Dr. Robert Levy has recommended oxygen inhalations during the acute attack. We have used them, employing the well-known oxygen tent for the purpose. The patients were made more comfortable, but we have not seen that the procedure had any effect as regards saving life.

The question that nearly always comes up when one sees patients in consultation is, shall digitalis be used? Having in mind the pathologic condition of the heart in acute coronary occlusion, infarction with softening, we have been afraid of using digitalis in adequate doses and we are glad to see that this is the opinion of most writers. If, however, there is auricular fibrillation or congestive failure as a sequel of the coronary attack, then

digitalis is indicated as it would be if coronary occlusion had not occurred.

If cardiac stimulation is necessary, and very frequently it is demanded, my favorite remedy is caffein sodiobenzoate hypodermically, using an ampule containing 0.5 (7½ grains) of the drug. When conditions are less pressing, the caffein sodiobenzoate may be given by mouth in doses of 0.12 to 0.20 (2 to 3 grains).

If diabetes exists, insulin should be withheld as it is dangerous in cases of coronary occlusion. Its use would only be justified in threatening coma. One of us (S. E. H.) had a death following shortly after one dose of insulin in a case of diabetes with angina pectoris. Gigon has reported a case of death in cardiac decompensation after three doses of insulin (Klin. Wochenschrift 2, 1670, 1923), and others have noted cardiac pain during insulin hypoglycemia.

OPERATIVE TREATMENT OF RUPTURED DUODENAL ULCERS

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Read before the New Jersey Surgical Society, Newark, January 31, 1932

During the last decade there have been admitted to the Newark City Hospital a total of 245 ulcers of the stomach and duodenum with a total of 99 deaths. Of the 245 cases, 146 have been of the perforating or ruptured type. In other words, over half have been acute surgical emergencies.

It has been my good fortune to have operated upon 16 of this type with but one death and that one a complicating lobar pneumonia. During this period I have consistently followed the teachings of Deaver of this country and Walton of England. Fully realizing the seriousness of the condition we are combating, we are at the same time cognizant of the fact of being confronted with a double problem, that of repairing the "blow-out" and at the same time remedying a condition which was probably the underlying cause.

The repair of the ulcer is, of course, the primary object at this time, the same being

accomplished by wide embrocatting sutures of chromic cat-gut, placing the sutures parallel with the lumen of the duodenum. By so doing, we practically obliterate the lumen by bringing the normal intestinal walls together wide of the indurated area; thus, we have performed a cat-gut resection. We do not think the use of cloth wipes is a good procedure, but prefer the use of the suction tube in the removal of foreign material, for the less trauma, the better.

A posterior-gastro-enterostomy is now performed. We do not waste time searching for the most dependent part of the stomach, but do endeavor to secure a portion nearer the pyloric rather than the cardiac end. After inverting the stomach and bringing the transverse meso-colon into view, an incision is made in an avascular spot, the stomach wall drawn through and clamp applied, being sure to have at least a two-inch area for anasto-

mosis. Reaching over to the left of the spine, we identify the ligament of Tritz, bringing up that portion of the intestine we feel emerging from it which one recognizes as jejunum. This little manoeuver saves time in identifying the elusive piece of intestine. Allowing slack enough for a short loop the clamp is applied to the jejunum, allowing enough surface for at least a two-inch anastomosis. It is well to fortify against spillage by placing a napkin beneath the two clamps.

The peritoneal anastomosis is made with a continuous suture of silk or linen thread, the mucous membrane, with a continuous suture of chromic cat-gut No. 1, every other stitch of this suture being locked, as this is a hemostatic suture. Each end of this suture we tie to the silk one. This not only keeps the knots on the outside but doubly closes the angles. We do not anchor either the stomach or jejunum to the meso-colon as many advise. We believe that the rent in the meso-colon rapidly forms adhesions with the stomach, thus preventing herniation. A Penrose drain is placed in the lower angle of the wound, extending into the pelvis and the abdominal incision closed by retention suture of silk-worm gut, plus layer sutures of chromic and plain gut. The entire procedure should not consume over 50 minutes. After 72 hours the Penrose drain is removed.

In our series of cases we have been fortunate in securing them early, from 2 to 6 hours, although two cases were ruptured 11 and 12 hours respectively. The oldest was 45 years of age, the youngest 22. The latter case had been operated upon two years previously for a ruptured ulcer, a simple suturing having been performed.

The subject of treatment in ruptured ulcer is still in the controversial stage, numerous articles having been written upon the subject. Eliot, Corscaden and Jamison, of London, in reviewing 75 cases of recurrent ulcer, are free to admit that if a gastro-enterostomy had been performed it might have prevented a recurrence. Morley, who has advised against the operation, has had 11 recurrences out of 47 cases, while Paterson has had 17 out of 33. Walton, in a series of 59 cases, operated 19 recurrent ulcers that had previously been oper-

ated upon by other men. Deaver reported a series of 56 cases in which the ulcer was repaired and then a posterior gastro-enterostomy was performed with but two deaths, the first and last one.

It is a more or less conceded fact that the easiest and safest method of curing a simple ulcer after its several medical cures is a posterior gastro-enterostomy. In fact, Mayo claims that it is a cure in about 90 per cent of the cases. Why, then, should the surgeon have any hesitancy in reducing the chances of a recurrence to 10 per cent. A simple suturing does not cure or even improve the underlying cause, but does leave him in the same gastric condition that he was in previously to the perforation, plus the prospect of a repetition of his perforation at some future date.

On the return of the patient to consciousness, he is placed in an almost sitting position. This allows any foreign material to gravitate into the pelvis where lymphatic absorption is slow and where the drain has been placed. The position is maintained for at least a week, when we feel that infection, if any, has been overcome. The reclining posture may then be assumed.

Five hundred cc.'s of 5 per cent glucose in normal salt solution is given intravenously every 8 hours for the first 24 hours as nothing is given by mouth during this period. Next 48 hours water is given in increasing quantities up to one ounce; the next day one ounce of orange juice is given on alternate hours; the fifth day, peptonized milk in ounce quantities is added; eighth day, gruels with no seasoning; tenth day, purees with soft bread and a small amount of butter; twelfth day, cup custards and gelatins are added. Upon his discharge the Alvarez diet for ambulatory cases is given. Tobacco and all alcoholic drinks are forbidden. All teeth should be repaired if necessary and strict dental hygiene maintained.

We realize that much of the above is elementary, but we feel that the results obtained fully justify such detail. While the series is not a large one, we feel fully warranted in recommending such a procedure as posterior gastro-enterostomy in conjunction with the repair of ruptured duodenal ulcers.

GASTRO-INTESTINAL MANIFESTATIONS OF FOOD ALLERGY

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From the Gastro-Intestinal Service of the Long Island College Hospital. Presented before the Atlantic County Medical Society, Atlantic City, N. J., November 18, 1932.

In recent years the subject of allergy has become one of the most frequently discussed problems in medicine. Respiratory manifestations (asthma and hay fever), skin manifestations (urticaria, eczema, et al.), and even neurologic manifestations (migraine and epilepsy) have been fairly freely admitted to be of frequent occurrence, but for some reason considerable controversy has occurred in regard to the gastro-intestinal manifestations, which are undoubtedly the most common. There are probably very few persons who are not aware of some more or less definite symptoms which always occur after the ingestion of certain foods. The mildest of these symptoms may be described as "gas" or heartburn, whereas diarrheas, "bilious attacks" and abdominal pains are often thus associated. A large proportion of the so-called "nervous indigestion" or "intestinal toxemia" cases belong in the allergic group. In a large series of private patients covering a period of fifteen years, who came to me for the relief of purely gastro-intestinal symptoms (see Table I) 13.3 per cent belonged in the allergic group, and in a more recent series 25.7 per cent were allergic,

observation of gastro-intestinal cases has been quite incidental.

The various problems connected with allergy in general are still the subject of much discussion. The *cause* of allergy is not known, although its very definitely hereditary nature has been repeatedly demonstrated. Its close analogy to infection and immunity is quite marked, and yet immunologists are divided as to whether sensitization corresponds to immunity or to susceptibility to infection. Whether a whole or split protein, even down to the amino-acid group, is responsible for the reaction has not been decided upon, although either might be the cause. Reactions after the ingestion of milk, human or bovine, have occurred as a result of sensitization to food ingested by mother or cow, even though examination of the milk failed to show any such specific protein. It has long been known that drugs, chemicals and even physical agents, such as light, cold, heat and electricity, may in certain sensitive individuals produce reactions corresponding almost exactly to so-called protein reactions. That endocrine dysfunction may be an etiologic or contributing factor is suggested by the frequent origin or cessation of allergic symptoms at periods of endocrine instability (menstruation, pregnancy, puberty and the climacteric), by the frequent evidence of disturbed endocrine function during allergic attacks (pituitary, thyroid, ovarian and adrenal) and by the fact that administration of various endocrine preparations may produce quite a marked effect on the symptoms during an attack and in some cases prevent or abort attacks. That focal infection is in some way connected with the problem of allergy is also suggested by the fact that some individuals cease to have allergic manifestations after a thorough eradication of all infective foci, yet on the other hand it has been pointed out that sensitization to bacterial proteins or to the various complicated products elaborated at the site of a focal infection may produce simply

TABLE I
GASTRO-INTESTINAL ALLERGY
Frequency of Occurrence in Private Patients with Gastro-Intestinal Symptoms

T'l No. Studied	Allergic Cases	Per Cent	Cases with	
			G.-I. Allergy	Per Cent
2868	382	13.3	277	9.6
544 (recent)	140	25.7	99	18.7

so that it would be safe to say that in fully 20 per cent of all sufferers from gastro-intestinal symptoms allergy plays an important etiologic role. It is interesting to note that among 382 patients showing gastro-intestinal allergic symptoms, skin manifestations were the most frequent allergic complications, with migraine almost as frequent and the respiratory manifestations relatively uncommon. This places the group of patients here reported into quite a different category from those reported by allergists whose main interest has been the study of asthma and hay fever, and whose

another allergic manifestation, to be dealt with separately in the same way as the others—by elimination. The problem of bacterial allergy is important, but does not come within the scope of this paper.

MORBIDITY

The *morbidity* of this condition has already been discussed as regards the frequency of its occurrence. The sex incidence shows no particular preponderance—55 per cent of my patients were females and 45 per cent males. The age of my patients varied from 7 to 71 years, the average being 39.5 years, the age of onset of symptoms being most frequently at puberty, in early married life and at the menopause. The frequency of occurrence of other actual lesions in addition to allergy is shown in Table II, in which a group of 159 allergic cases

TABLE II
GASTRO-INTESTINAL ALLERGY

Observations in 159 Cases of Allergy		
Disease	No. of Patients	Per Cent
Allergy alone	19	12
Chronic G.-I. Infection	114	71.7
Rectal diseases	15	9.4
Cardiovascular disease	22	13.8
Endocrine disorders	9	5.6
Focal infections	146	91.8

showed the presence of a "chronic gastro-intestinal infection" (peptic ulcer, cholecystitis, appendicitis, colitis, etc.) in 114 or 71.7 per cent. This points to the need for a thorough gastro-intestinal study by a competent clinician with the collaboration of an expert roentgenologist in all allergic cases. The fact that in our series of 159 patients (see Table III) 30.8 per cent had been subjected to previous unsuccessful surgical operations indicated inefficient or incomplete study preliminary to operative interference.

TABLE III
GASTRO-INTESTINAL ALLERGY

Previous Operations in 159 Allergic Cases		
Operation	No. of Patients	Per Cent
All kinds	*49	30.8
Appendectomy	34	21.3
Pelvic operations	20	12.5
Gall-bladder operations	4	2.5

*Note: 49 patients had 68 operations.

MANIFESTATIONS

The gastro-intestinal manifestations of allergy consist as in the case of allergy of the respiratory tract, mainly of two types of reac-

tion—mucosal and neuromuscular. The *mucosal manifestations* may be mild or quite severe and extensive. Hyperemia of localized areas like the mouth, esophagus, stomach or rectum, or generalized throughout the entire gastro-intestinal tract, resembles inflammation and produces identical though at times temporary symptoms. Angioneurotic edema may involve only the mucosa or may invade the whole wall and may also be local or general in its distribution, causing more or less narrowing of the lumen, with symptoms often resembling an acute intestinal obstruction. Areas of ischemia may occur and may result in necrosis, sloughing, ulceration and hemorrhage. Just as "canker sores", small mucosal ulcers in the mouth may be of short duration, small gastric or duodenal ulcers may also occur and quickly disappear. There may be also submucosal hemorrhages, producing the petechial or purpuric areas often seen in rectum or sigmoid, which may break down and bleed. Repeated occurrence of any of the more severe reactions will eventually result in fibrosis and if chronic irritation constitutes a factor in the production of carcinoma, allergy must be reckoned with as a cause of this scourge.

The *neuromuscular manifestations* consist of motility disturbances, retrostalsis and spasms. Hypermotility may be manifested by a feeling of peristaltic unrest interpreted as "gas" by colicky pains or by diarrheas of varying intensity. Diarrheas associated with mucosal sloughs and hemorrhages give the exact picture of so-called ulcerative colitis. Hypomotility, often associated with colon spasms, may be manifested merely by a constipation or when severe and associated with mucosal changes may suggest real obstruction. Spasms may occur in any part of the gastro-intestinal tract and it is undoubtedly true that some otherwise unexplainable spasmodic conditions may be entirely due to allergy. These include esophagospasm, cardiospasm, pylorospasm, colon spasm and even anal sphincter spasm. As a rule, mucosal and neuromuscular manifestations occur together.

The *gastro-intestinal allergic reactions* to food may be direct, due to irritation of the mucosa by the food coming into direct contact with it, or indirect, as part of a general

reaction to the absorbed food material. *Direct reactions* may occur immediately after ingestion of food when they are confined to the upper part of the tract, or may occur later if the lower part is the site of reaction. *Indirect reactions*, as they require absorption of food before their occurrence, will of necessity occur later after eating, although the time of occurrence is of course dependent on the rapidity of absorption of the offending food. The various factors involved in this process may be further influenced by the addition of easily absorbable solvents to the food, notably alcohol, which in some individuals may indeed be necessary to the production of a reaction.

SYMPTOMATOLOGY

The *symptoms*, as suggested by the manifestations previously mentioned, may be quite variable. There may be only mild retrostaltic symptoms, such as epigastric uneasiness or "gas", belching, heartburn, sour regurgitation, nausea or vomiting or typical peptic ulcer symptoms may be present due to an allergic ulcer. There may be dysphagia, spasmodic vomiting, abdominal colicky pains or rectal pains and spasms. There may be diarrhea or constipation, either one associated with the passage of excessive or abnormal mucus—the familiar "mucous colitis". In severe cases of edema or spasm, the condition may resemble an acute abdomen or an acute intestinal obstruction, and useless operations have frequently been performed in these types of cases. Biliary or renal colic is often closely simulated and, if the cases are not carefully studied, may also result in useless surgery. Severe ulcerative lesions may, as mentioned before, produce a typical ulcerative colitis and in cases of this kind which have proved intractable to the usual treatments the discovery of the allergic cause for the symptoms may be the only means of saving a patient's life.

DIAGNOSIS

The *diagnosis* of gastro-intestinal allergy necessitates a very careful, detailed history. Even this is liable to be deceptive, owing to the fact that allergic symptoms may be identical with those due to actual lesions and also because such lesions are so often co-existent.

To avoid pitfalls, it is always necessary in a case where allergy is suspected to conduct a complete and thorough gastro-intestinal study. The *history*, as in any gastro-intestinal case, constitutes the most important single diagnostic aid. From the history the presence of allergy is to be suspected when any of the following factors are present:

(1) A family history of some manifestation of allergy, bearing in mind the fact that while the occurrence of allergy follows very closely the Mendelian principles of heredity, the manifestations may not always be in the same part of the body. For instance, a father with gastro-intestinal allergy and a mother with asthma may have children exhibiting hay fever, urticaria or migraine.

(2) A previous history of other allergic manifestations in the patient's earlier life or the coincident occurrence of such other evidences of an allergic tendency. In this connection intermittent skin conditions, periodic upper respiratory symptoms, so-called "bilious headaches" (migraine) and the occurrence of heartburn or "repeating", or diarrheal stools after certain foods give a valuable clue to the condition.

(3) The occurrence of periodic and difficultly explainable gastro-intestinal symptoms, either at irregular intervals or, in the case of people living on a very systematic diet as in institutions, their occurrence on certain days of the week when the principal article of food may be the same.

(4) The onset of symptoms at puberty, pregnancy or the menopause, or after some great emotional stress, may also be suggestive.

The *roentgen* ray may also be of help in diagnosis, in that it may frequently disclose evidences of both the mucosal and neuromuscular manifestations of allergy. As would be expected, the older, more chronic lesions produced by prolonged and continued ingestion of offending foods, such as chronic gastritis and chronic colitis, especially ulcerative colitis, give the most marked roentgenologic findings and these are the same as in cases where these lesions have a different etiology. If the radiologic study happens to take place during an allergic reaction, the spasms and hypermotility or the peculiar appearance due to angioneurotic

edema of stomach or bowel may be seen and prove to be absent on a later check-up. Where localized, such temporary lesions sometimes resemble neoplasms, and their presence accounts at times for the marked divergence of opinion of different roentgenologists after studies made within short periods of time. It is interesting to note, fluoroscopically, the occurrence of the reaction in the stomach when the medium used for making the barium suspension—milk, buttermilk, cocoa, etc.—happens to be one to which the patient is sensitized and to which he reacts in a direct way. If a preliminary small barium and water mixture is used to study the rugae, there can be seen a sudden puckering and coarsening of the mucosal folds as the offending food reaches the stomach, together with motility disturbances such as spasm, mass contractions or very rapid peristalsis with “writhing” and often reverse peristalsis in the duodenum. From these observations, our roentgenologist, Dr. A. L. L. Bell, has frequently suggested the diagnosis of allergy in cases where it had not previously been suspected.

The finding of an *eosinophilia* at the time of an attack, or the finding of eosinophiles in the stool, or even in gastric contents, is of value where found to be present and where coincident protozoal infestation can be ruled out.

The *relief of symptoms by a dose of adrenalin* subcutaneously or sublingually, or of ephedrine by mouth, may give quite spectacular evidence of the nature of the symptoms.

The *finding of the allergic factor* constitutes the most important part of the diagnosis. Many clinicians still discuss the cutaneous tests as if they constituted the surest method for obtaining this information, and even dismiss the possibility of allergy being present if the skin tests are negative. Yet today we feel that the cutaneous tests—by the scratch method, the intracutaneous injections or surface contact—are not infrequently more deceptive than enlightening, although in cases where the allergic reaction after the ingestion of the offending food is direct and immediate or where a skin manifestation is coincident, they have at times been of considerable value. Cutaneous reactions may be negative in the case of substances definitely proven to be the cause of trouble

and may be even strongly positive in the case of foods which produce no demonstrable symptoms. In any event, it is necessary to check the findings by avoiding the substances which produced skin reactions and then try them separately, watching carefully for symptoms. The *study of the diet* is the most valuable aid in the discovery of the allergic factor. At times, as mentioned before, the history of certain symptoms after definite foods, will be of help. But, as a rule, the keeping of a careful record of all food ingested together with notes on the patient's symptoms from day to day is necessary. It must be realized that whenever a small amount of food to which a person is sensitive is ingested, a reaction will invariably occur and that rarely is only one food responsible for symptoms in a given case. At times it may be most expedient to begin with a very simple diet, like the old Bulkeley diet of rice and water, waiting for cessation of symptoms, and then making daily additions of one or more foods and watching for the effect. Or it may be more desirable, in patients who could not stand the restricted diet, to start with a full diet and gradually eliminate foods until symptoms cease, later trying them out again to confirm the diagnosis. The “elimination diets” of Rowe, modified by the observation of “group allergens” as suggested by Vaughan, are of value in this connection, but in the case of an intelligent coöperative patient, explaining the principles involved and suggesting such variations in the daily menu as may be indicated by suspicions in regard to different foods, have proved most satisfactory in my experience.

TREATMENT

The *treatment* of gastro-intestinal food allergy consists of the treatment of the actual attack and of the treatment of the allergic state in general to prevent future attacks.

The *treatment of the attack* must concern itself with the following problems:

(1) In very severe reactions where an acute abdomen is suspected and operation is being considered it is desirable to apply some therapeutic measure which, while not endangering the patient's life by stirring up gastro-intestinal motility, may have a rapid and defi-

nite effect on the allergic reaction. In my experience, the hypodermic or intramuscular injection of adrenalin (.7 to 1 cc.) has frequently produced the most spectacular disappearance of symptoms, a patient in great pain and almost ready for operation being found a few minutes later sitting up in bed entirely free from pain and asking for food. At times adrenalin, and even ephedrine, produce such a marked thyroid stimulation as to be very distressing to the patient even though the gastro-intestinal symptoms are relieved, so that in the case of milder allergic reactions patients will prefer the allergic reaction to the thyroid disturbance and will refuse to avail themselves of this form of relief. The possibility of producing permanent thyroid changes from such repeated stimulations must also be borne in mind. Pituitrin will occasionally produce an effect where adrenalin fails or proves to be undesirable. At times calcium and parathyroid may also produce a fairly rapid alleviation of symptoms without the thyroid irritation and may also be tried in doubtful cases.

(2) Elimination of the offending factors would seem to be desirable, and where no damage could be caused thereby, lavage, catharsis or an enema may be of use. The pushing of water by mouth is also of value. However, as in some individuals most of the reaction occurs during or after the absorption of the offending food protein, the reaction may cease when what is left of this protein has become dehydrated in the lower part of the colon. I have seen patients develop secondary reactions when a saline cathartic was taken after an attack had subsided, probably due to the liquefaction and absorption of some of the offending protein which had previously been in a dry state. Castor oil is probably the best cathartic to use, as it has been shown to have a detoxifying effect in addition to being a most efficient bowel cleanser.

(3) To restore normal function in the gastro-intestinal tract it is important that feeding be started at once, even during the attack, making the diet very simple, to avoid the repeated ingestion of the offending factor. Frequent feedings will stimulate the secretory and motor functions of the gastro-intestinal tract

and will often materially shorten the usual duration of the attack.

In general, *treatment* of a patient with allergy concerns itself not only with the treatment of the allergic condition itself, but with attention to all other factors influencing the general health of the individual. The most important point in treatment consists in the *elimination of the offending* food or foods from the diet. If these foods are such that a patient can conveniently continue to live without eating them, their avoidance permits the more or less gradual restoration of normal gastro-intestinal function. But if the foods are those commonly present in a normal diet, such as milk, egg, wheat and potato, it is usually desirable to attempt to desensitize the patient to these foods. In this connection, it is well to note that, when desensitization has been established, it will be necessary for the patient to take at least some of the food each day, as sensitization is liable to return very rapidly unless this is done. It is the failure to realize this fact that has hitherto made desensitization to pollens in cases of hay fever an annual event, whereas if patients could be supplied with pollen preparations for daily inhalation throughout the year this would be entirely unnecessary. In gastro-intestinal allergy it is therefore not desirable to desensitize the patient to a food which could not conveniently be taken daily.

Desensitization may be either specific or non-specific. Specific desensitization may be accomplished in several ways:

(1) The patient may be given gradually increasing doses of the offending food or foods by mouth, starting with a drop of milk, a drop of a diluted solution of egg or a small pellet of bread or potato. The rate of increase in the dose is increased as the doses get large—for instance, in the case of milk, the number of drops given on successive days may be as follows: 1, 2, 3, 4, 6, 8, 10, 13, 16, 19, 23, 27, 30; and after this teaspoonfuls will be given as follows: $\frac{1}{2}$, $\frac{3}{4}$, 1, $1\frac{1}{4}$, $1\frac{1}{2}$, 2, $2\frac{1}{2}$, 3, and so forth. When a dosage will be reached beyond which symptoms will invariably occur, the patient's diet is adjusted to a quantity just short of producing such a reaction. This quantity may be very small, or at times desensitization may be impossible.

(2) The patient may be started on hypodermic injections of purified proteins of the foods causing reactions, later shifting to the oral method as the doses are increased. This is rarely necessary and may at the start even be dangerous, as severe anaphylactic reactions have been known to occur after hypodermic administration.

(3) Recently the use of a specific peptone of the offending foods, known commercially as Pro-peptan, has been tried out, and the use of one or two tablets of this preparation, taken forty-five minutes before the ingestion of the food, will practically always prevent a reaction, and it is claimed, although I have not personally had this experience as yet, that if continued for a sufficient length of time, the daily ingestion of food in this manner will produce permanent desensitization, thus obviating the necessity for continuing the peptone.

Non-specific desensitization has been recommended, the two principal methods consisting of the intravenous injection of a foreign protein, and the use of peptone. A foreign protein reaction will at times cause a disappearance of allergic symptoms for some time, although I have never seen a permanent result from this treatment. I believe that in order to get a result, a severe febrile reaction is necessary, my experience with small, repeated, gradually increasing doses having been very unsatisfactory. It is well to make sure before giving intravenous injections that the patient is not sensitized to the protein used, but even with this precaution it must be borne in mind that an allergic individual may have a severe anaphylactic reaction to any intravenous injection, so that this treatment is not without real danger. Adrenalin must be in readiness. The same precaution is necessary in the case of intravenous injections of peptone solution which was highly recommended several years ago. The oral administration of peptone solution (non-specific), one-half to one hour before meals was recommended about seven or eight years ago and in some cases prevented reactions although, in general, experience showed that if while peptone was being administered symptoms were obviated or ameliorated, the discontinuance of the use of the peptone resulted in a return of the symptoms. The use

of a specific peptone, mentioned before, was the result of an attempt to improve on the known action of non-specific peptone and so far has seemed to be of considerable value.

The *removal of infective foci* has resulted in some cases in the immediate cessation of allergic phenomena, but in my experience this happy result is rarely, if ever, permanent. However, the cleaning up of focal infections and other hygienic measures such as attention to a balanced dietary, fresh air, exercise, rest and recreation are important aides in improving the general condition of a patient whose health has been materially depleted as a result of his gastro-intestinal symptoms.

Endocrine therapy is sometimes of value, being based on the theory that endocrine imbalance plays a part in the etiology of allergy. The value of adrenalin in cutting short an acute reaction has suggested the continued use of adrenal therapy, but the danger of repeated stimulation of the thyroid makes this a little risky. The use of parathyroid and calcium has in some cases produced not only rapid results during an allergic reaction but seems to be safe and often efficient in preventing attacks. Other endocrine preparations have been tried but have shown no consistent results.

PROGNOSIS

The *prognosis* of allergy in general is not good. An allergic patient will always show a tendency to recurrence of allergic manifestations either in the same organs and often to new factors or in other regions. There may be periods of remission for months or years during which apparently all sensitization has disappeared and then suddenly either without apparent cause or as a result of an emotional upset, an endocrine disturbance or an acute illness the patient will be as allergic as ever. At puberty, or more particularly at the menopause, there may be a cessation of allergic symptoms which may at times be permanent, and during pregnancy allergic symptoms may disappear or, in other cases, they may be present only during a pregnancy.

There is one factor concerned with gastro-intestinal allergy which I do not recollect having been mentioned but which may be of considerable importance. In gastro-intestinal al-

lergy, where repeated or continuous irritation of the gastro-intestinal tract is taking place, this chronic irritation may well be an etiologic factor in the production of cancer. Occasionally I have seen patients develop gastro-intestinal carcinoma during my attempts at treating an allergy of long standing, but in order to determine, if possible, what proportion of carcinoma patients gave a history of previous allergic manifestations, I have studied histories of a series of private patients in whom, unfortunately, the carcinoma finding had so predominated the picture that I fear allergic symptoms were not sufficiently inquired into. The results were as shown in Table IV. While the

TABLE IV
INCIDENCE OF PREVIOUS ALLERGY IN CARCINOMA

Location	Total Pts.	Pts. with Allergy	Per Cent	Pts. with G.-I. Allergy	Per Cent
Stomach	31	18	58	13	42
Colon	8	1	12.5	0	0
Rectum and sigmoid ..	16	5	31	4	25
Esophagus	6	5	83	5	83

series of cases shown in this table is too small to warrant the drawing of any definite conclusions from the findings, it is very interesting to note that the esophageal carcinoma cases showed a very large incidence of previous

allergy, the gastric cases about double the incidence shown in our general run of cases, the rectal cases no more than the general average and the colonic cases a surprising absence of any previous allergic symptoms. The inference would be that if allergy plays a part in the etiology of cancer, it is the direct irritation of esophagus and stomach caused by the repeated ingestion of foods to which the mucosa of these organs is sensitive, which is the irritative factor so necessary to the production of cancer. A further study along this line may reveal more definite evidences of the connection between allergy and cancer.

SUMMARY

(1) Gastro-intestinal manifestations of allergy are very common and are frequently overlooked.

(2) They may be mild and chronic or may be severe and acute, resembling an acute abdomen.

(3) The diagnosis depends on the history and on a careful study of the effects of dietary changes. A complete gastro-intestinal study is imperative.

(4) The treatment consists in avoidance of the offending factors and in general hygienic measures.

(5) Allergy is not curable.

ANOREXIA IN CHILDREN

By F. ELMER JOHNSON, M.D., New York City

Read before the Associated Physicians of Montclair and Vicinity, November 24, 1933

I shall not discuss physiological anorexia associated with illness, but that brought on by bad management. It is my purpose to stress the prophylaxis and to make my remarks as practical as possible. I shall not dwell on scientific theories. That this is a real problem and should give all of us much concern, I am sure you will agree when I state that three-fourths of our new patients in the office come with this complaint. It is also the most prevalent diagnosis in the pediatric department of our dispensaries. The anxiety of the parents over this lack of appetite is unbelievable. I shall now give an illustration of the type of case I shall discuss.

A 6-year-old boy entered St. Luke's Hospital September 25, 1933. He was the only boy in a family of 4 children. The next older child was 6 years his senior. The mother gave a story of difficult feeding for 3½ years. Up to 15 months of age he had taken cereals, strained vegetables and a quart of milk in bottles. At this time he had an illness which was called by the doctor "intestinal grippe", with fever and diarrhea. After this illness he refused vegetables and cereals, but resumed milk in bottles. At 16 months, however, because a new nipple was substituted for an outworn one, he refused to take milk.

At 18 months he was fasted for 48 hours in an institution, and then was given his food through a tube. He developed a severe attack of ketosis and was thereafter given his way. Since that time the following diet has been given every day. He refused to take any other kind of food.

3 or 4 slices of toast—buttered and retooasted.

8 saltine crackers or cheese wafers.
6-8 oz. orange juice.
1 oz. milk chocolate bar and peanuts.
6 teaspoonfuls cod-liver oil.
Iron tonic—saccharated ferric carbonate—
0.6 gm., t. i. d.

Occasionally one-half a banana once a week.

Iced tea in summer.

His development had been to all appearances fairly normal. He was a little underheight and about 5 pounds underweight. The cod-liver oil and iron saved him in part, but his protein requirements were very inadequate. Why he did not develop nutritional edema is difficult to say.

Upon entrance to the hospital he had acetone and diacetic acid in his urine. After 48 hours of voluntary fasting his CO_2 combining power had decreased to 24 volumes per cent. The urea nitrogen was 29 mg. per 100 c.c. This was an indication of dehydration. He was then fed by tube for three days, and was told this would be stopped if he would eat. A dose of five units of insulin was given before meals. He said he didn't mind the tube at all. He was rated a superior child by the psychologist, with an intelligence quotient of 120. He enjoyed thoroughly the attention he received from the nurses and doctors.

He was moderately anemic with a 64 per cent hemoglobin determination, and 3,900,000 red blood corpuscles. At this time he was free from acidosis and it was decided to fast him until he ate. He was put in a ward where he could play with other children. He was placed at a table with two other children who had excellent appetites. He refused food for seventy-two hours and then slowly and steadily ate more and more. After gaining five pounds, he was sent to our convalescent home where he continued to eat and gained three and a half pounds. His mother was allowed to visit him and watch him eat, and he has since returned home with excellent results.

In these days of stress it is anomalous that children are forced to eat and that some of their parents go hungry. Dr. Hugh Chaplin, who is in charge of a clinic where 80 per cent of the patients are on state relief, tells me that there is less malnutrition among the children than before the depression, but many adults show visible evidences of illness and malnutrition. His statement is reliable because he has used the same criteria for determining malnutrition over several years in the same clinic. This sacrifice on the part of the parents in many cases seems unnecessary because much of the food is wasted in forcing it on the children.

This problem has come into evidence since pediatrics and dietetics have developed into recognized specialties. The focusing of attention by doctors, dieticians, nurses, and parents

on the diet of the child has been the child's undoing. We have forgotten to practice the art of feeding children, because our hands are forced by the scientific advances in nutrition and the widespread advertising by the food manufacturers. In our childhood we knew the joy of eating even if there was less science and more malnutrition (due to impure and ill-chosen food). Twenty-five years ago we did not have the problem child to plague us, nor the child psychologist or behaviorist. Of course we do not want to return, but we do want to maintain a normal attitude toward food and a wholesome appetite, and at the same time give adequate and proper food.

The science of nutrition has grown so rapidly that we are in a muddle to know how to put all the new discoveries in amino acids, mineral salts, vitamins, and water metabolism to practical use. It is our problem to practice the art of feeding children so that they will have all the advantages of these discoveries and *still enjoy eating*.

When caloric feeding came into vogue, we began to feed children quantitative diets. The layman began to think the calorie represented a unit of nutrition, and knew nothing and cared less about the calorie as a unit of food combustion. If the child took adequate calories that satisfied him. He cannot appreciate that what is eaten is not always assimilated. Dr. Holt once said, "Not what one eats but what one digests, matters." When we began to add foods selected for their proper content of amino acids and vitamins, and also gave exotic accessory foods, we discovered that the child rebelled and rightly so. Such a case is the following:

A girl, aged 8 months, was brought to the office January 27, 1932. She had been offered a normal diet for her age, including cereals, vegetables, broth, beef-juice, and plain milk four times a day. The weight was 16½ pounds and the height 26½ inches. There were four teeth, and the tonsils were large. The baby was very irritable, and all food was forced by the nurse. The nose was held, the mouth forcibly opened and the food spooned. This had been going on for a month. For some time the baby gagged at the sight of food and, as the nurse naively said, forced herself to vomit. With the idea of washing out the stomach, I found that I could not pass the tube beyond 6½ inches from the lips. An x-ray was then taken after barium, and in one roentgenogram out of several, a con-

striction was found at the cardia with dilatation above the constriction. A laryngologist passed an endoscope and found an obstruction at the cardia which he believed was a congenital malformation. On several occasions he passed graduated bougies dilating the esophagus to the normal size.

Believing the obstruction organic, I taught the nurse to pass a small catheter three times a day and to give a concentrated milk mixture. Finding that the tube at times would enter the stomach without resistance and other times would stop at $6\frac{1}{2}$ inches, I came to the conclusion we were dealing with cardiospasm due to forcing. At this juncture we tried to separate the baby from the parents and nurse in the hospital, but the mother's love was too great to allow her to stay away. The mother continued to officiate at feedings.

The family then betook themselves to Philadelphia to see Dr. Chevalier Jackson. He, wise man that he is, would not consider treatment unless the family returned to New York and left the baby in his hospital.

In two days, without instrumentation, but with fasting, the child ate normally.

This is a case of forcing food with resultant cardiospasm.

Incidentally in the three months the baby was under my care she gained three pounds.

Dr. Davis, of Chicago, has made a real contribution to this subject. She took a group of infants, too young to have prejudices, away from their parents and offered them all kinds of foods three times a day. If one food was chosen, the plate was refilled as many times as desired. She found that although a child would have a debauch of one type of food at one meal, in the course of a day or two he would choose a well-balanced diet. It seemed to her that the infants had a natural instinct to select the proper foods if they were offered in more or less natural state. Of course, she did not offer them sugar, candy, or pastries, but carbohydrates in the form of breadstuffs, cereals and potato and other vegetables. She has followed these children for years without interference from parents, and they have developed normally. Two of the infants had active rickets at the beginning of the experiment. One was given cod-liver oil. Both recovered, showing that the one not receiving cod-liver oil chose his food wisely for vitamin content. There was no scurvy. It is unfortunate that so much artificiality has developed in our dietetics. Observers of Dr. Davis' experiment have been impressed with the eagerness in which these children eat their food—unseasoned and unsweetened.

The manufacture of sugar is only of comparative recent times, and I believe the human race would do very well without it. Sugar is too concentrated and burns too easily. Our digestive organs were given to us to manufacture sugar from ingested starch. It doesn't take much sugar to add large amounts of heat units. Then again the adjuvants for milk so widely advertised, such as toddy, cocomalt, ovaltine, add large amounts of food in the form of carbohydrate in small bulk, only to take the place of other foods to the child's disadvantage and his dislike for less tasty foods.

Twenty-five years ago Dr. Holt reviewed the dieteries of a hundred children and discovered that the proportion of calories obtained from the carbohydrate, fat, and protein eaten by each child was almost identical—55 per cent of the calories were in carbohydrates, 30 per cent in fat, and 15 per cent in protein. The same study now would show over 75 per cent of the intake to be in the form of carbohydrate, and a corresponding decrease in protein and fat. This is discouraging, because we know the importance of protein and vitamins in a child's growth. This is one reason for our anorexia. The carbohydrates in the form of candy, ice-cream, and cake furnish so much heat that a child cannot eat much more. The anorexia for this reason is only apparent, and not real. The mother at least cannot understand why her child cannot eat more. For example, 10 oz. of sugar will supply all the theoretical caloric requirements of a two-year-old child. The 1200 calories can also be given by 1 quart milk, 4 oz. ice-cream, 1 oz. heavy cream, and 2 oz. carbohydrate in the form of karo, ovaltine, etc. Incidentally this high carbohydrate feeding increases the susceptibility to colds as well as anorexia.

I have recently been appointed a member of a special committee of the N. Y. County Medical Society to study the children of our city for malnutrition, alleged to be on the increase in the past four years. When we asked ourselves what constitutes malnutrition, we all agreed that the weight and height charts were lamentably untrustworthy. The dependance of parents and doctors on weight charts has caused untold anxiety. To make their chil-

dren's weight conform to the standards of the charts is the principal cause of anorexia. Health, stamina, proper skin and tissue turgor are infinitely more important. One pediatricist has recently reported that he has thrown out his weight charts in order to overcome the invidious comparisons of his patients, and to discourage the urge on the part of the parents to make their children weigh the so-called proper weight for their height. For example, a child with pituitary dyscrasia may meet the requirements of the height and weight charts, but be far from normal.

When we were Hooverized in wartime, the slogan "Give every child a quart of milk a day" came into vogue. Next to too high caloric feeding, this has caused more anorexia than anything else I know. Many children can take a quart of milk and still have an appetite for other foods; but it is our experience that there are many others who, if made to take a quart a day, lose their appetite for everything else. They are then forced to take the other foods. It is true that milk furnishes, with the exception of iron, large amounts of mineral salts, particularly calcium. I find that a pint is taken better, and the additional food furnishes enough calcium. With the almost universal dosing with vitamin D there is a larger proportion of the calcium absorbed and utilized, and less milk is needed. Skimmed milk and pot cheese, which are less filling, do as well. It is simple to give calcium by attractive prescriptions, and at the same time not cause anorexia with large quantities of milk. Large amounts of cream in the milk probably lowers calcium absorption, because more insoluble calcium soaps are formed during digestion.

The forcing of food during dentition and disease is prevalent and causes much trouble. In the diarrheal diseases allergy to food is frequently caused by the increased permeability of the intestinal wall to unaltered protein.

Because milk is the principal protein food given to infants, it is next to egg the commonest food to which children acquire sensitivity. Usually the skin tests are unsatisfactory, but the history is suggestive. I wish to give a case history in illustration.

A nine months old baby came to the office December 5, 1931, with a complaint of vomiting for

three months. At two months the baby had ear trouble and refused to eat. An elaborate diet was prescribed with the quantities of food specified for each day. The mother followed directions, resorting to forcing, and the child gained until he weighed 21 pounds at 7½ months. The vomiting increased and the appetite decreased. The child vomited when he saw the mother approaching with his food. Diarrhea began and when I saw the baby, he had lost four pounds or about 20 per cent of this weight. He refused all foods including bottles. He was severely dehydrated, and was sent into the hospital. After a long siege of diarrhea, which proved to be bacillary dysentery, with careful feeding and transfusions he was discharged with a normal appetite and gaining. Whenever milk was given, the stools became frequent and filled with mucus. From April, 1932, until the present this child has had no milk, and has gained 14 pounds or nearly 100 per cent. He has been given his calcium in tablets.

This case illustrates the development of allergy by the forcing of food. He began to vomit, diarrhea followed and still the food was forced. This case shows a child can be raised without milk and in some instances to his great advantage.

The child over one year who comes to your office, and is taking his milk through a nipple, and is not gaining is a suspect of milk allergy. Milk has been his chief supply of food; and if he hasn't done well, it is a safe bet that milk does not agree with him. Temporarily milk may be taken away and his mineral salts added to his dietary with improvement in his appetite.

We see much secondary anemia, so-called bottle anemia, during the second year from taking a bottle. The baby enjoys sucking the nipple and takes more milk than he really wants, and refuses other foods. If the food is forced, we see our most pathetic victims of anorexia.

The stress of school homework, staying up too late at night, and too long hours of play, cause fatigue, and the tired child cannot eat.

Everybody who is interested in this problem should read Cameron's "The Nervous Child". He says in the preface that the nervous child is really the normal child with his natural reactions exaggerated. The child is naturally negativistic. He reacts negatively to demand; and if he is young, at the age when reasoning is of no avail, his negativism becomes very apparent. If told he must eat, he naturally resents

the command and often will go hungry rather than eat.

Another attribute of the young in the human species is the desire for attention. He enjoys being talked about at home and abroad and being made to eat. We will show later how this negativism and love of attention can be made to aid us in overcoming anorexia.

In our New York apartments, where families live so closely, these natural attributes are accentuated because of continual contact with the children and constant nagging. There is a tenseness due to the dangers of the street that make life difficult for both parents and child.

The only child, the child born after a long interval, and the only boy in a family seem to be the chief sufferers of this complaint.

Now, how can we prevent this condition which represents at least 75 per cent of our practice, and which is really as serious as a devastating disease? If we are cognizant that this condition occurs and we have the privilege of feeding an infant from birth, I believe it can be avoided. Every visit to the office should be seized upon as an opportunity to educate the mother in proper feeding habits. When the baby is born, if he is well he is naturally hungry. After he is warmed, his first discomfort is the pain of hunger waves in his stomach. His first instinct is to eat, and this instinct should never be lost if the child is brought up properly. We caution the mother, even on the breast, that the baby should never be fed longer than the time when he takes his food eagerly. If the child falls asleep or does not suck vigorously, he should be taken from the breast and made to wait until the next feeding. The continual patting the back to allow the escape of gas and the subsequent returning to the breast is to be discouraged. The mother is to be told the advantages of maintaining appetite even if this involves much crying. Regular intervals of feeding are encouraged, and from the beginning I give one bottle a day. This helps to overcome the prejudice of the infant to rubber nipples, and increases the baby's tolerance for cow's milk. If for any reason the breast must be stopped abruptly, weaning is made less difficult. As soon as the baby lets go of the bottle, it should be taken away. It should never be offered

more than once even if very little is taken. However, if the child refuses the nipple from his mother, it is good prophylaxis to have the bottle offered by some other person than the mother for several feedings until the prejudice is overcome.

At about one month of age or less, spoon feeding is taught by giving orange juice. We usually start with one teaspoonful, and increase one teaspoonful every day until one ounce is given every day. This is given by spoon in order that the child will later take other foods with the spoon without difficulty. When the child is three or four months of age, it is time to start a cereal; and this is a very critical time in the child's feeding history. We use a thoroughly cooked cereal served with some of the feeding formula over it, and this is fed with a spoon. Many babies will refuse to take the cereal. These are the babies that have refused to take the spoon when orange juice was offered. The way this problem is handled by the mother determines in a great part the child's whole attitude toward future feeding. If the mother stands over the child and makes him take the cereal, or goes to the extremity of holding his nose, the child acquires a distaste and prejudice which may be lifelong. The mother must be cautioned against this, and told to fast the baby until he is so hungry that he will enjoy the cereal. In other words, the cereal is offered every feeding, without bottles, until it is taken with avidity. If the cereal is put in the bottle and served, the training in spoon feeding is only delayed and made much harder. We always suggest that the cereal be made very thin with the formula, and that the lumps be mashed out thoroughly at first; and then the cereal is made thicker as the child begins to take the food. If a child has been trained to take cereal, the additions of other foods is made easier. However, the difference in texture and taste in vegetables which are usually added to the child's diet at six months of age may offer some difficulty. This is overcome in the same way, by never forcing, but by fasting until they are taken and enjoyed. From six months to the first year the physician should always keep in mind the goal of three meals a day without bottles. Egg, beef juice, and puddings

are added. At nine or ten months of age the child should be taught to take some of his milk from a cup, and at one year of age the bottle should be dispensed with entirely and milk offered in a cup. This is of tremendous importance in prophylaxis because it is my experience that, if a bottle is continued after one year of age, the baby will take more milk than he really wants because he enjoys sucking the nipple and not because he wants the milk. During the teething age and the age when children are particularly susceptible to infections, the taking of large quantities of milk merely from enjoyment of sucking nipples, and not from desire for food, may mean disaster. Intestinal indigestion, ketosis, convulsions, and anemia may result. The secondary or bottle anemia results because the child is taking more milk than is really desired to the exclusion of other foods. The milk does not give adequate iron. If at the end of a year we have taught the baby to take the milk from a cup, and he is taking a variety of foods, we are a long way towards preventing serious anorexia later. At this time the baby should be on three meals a day with a long interval between.

The next most important advance is good feeding habits in teaching the child to feed himself. This certainly should be accomplished by the fifteenth month in most children, and can be easily done if the child is left to his own devices. If food is left on a table in the kitchen and the child is put in front of it, he must go without if he does not eat, because it is taken away in a reasonable length of time and he must wait until the next meal. After a time he has learned two great lessons. One is that food is valuable and not something that his mother is trying to get rid of down his throat; and the other is that he has learned to do something for himself.

As I said before, every visit to the pediatric's office should be seized as an opportunity to instruct the mother. No opportunity is missed to teach the mother to bring her baby up with good feeding habits. If the child is taken sick and does not care for food, the mother is instructed to give only the simplest foodstuffs without milk, but with plenty of water or 5 per cent glucose solution. I venture to say that if this were carried out at the

onset of many illnesses, it would decrease the morbidity and mortality. Unfortunately, many mothers do not heed our instructions, and many deny themselves the routine visit to the doctor's office or clinic. Consequently we have a great number of children coming to us with this history of refusing to eat. When a child has fallen into this condition, we have the most baffling thing to treat that I know of. The mother has lived with the belligerent child so long that she is not impressed by simple measures. She becomes fatalistic, and believes that if the child is not fed, he will not eat. After an earnest talk of five or ten minutes trying to persuade the mother that the problem is simple, she will give the same answer, "Why, doctor, the child would not eat if I did not force." It is not unusual for me to see children eight years old fed by their mother. When these children come to us we do everything possible to eliminate a diagnosis of organic disease by a complete physical examination and appropriate laboratory tests. To send the child back, however, to the same environment and same attendants has usually proven unsatisfactory. The mother soon reverts to her former bad habits, forcing, nagging, scolding, and bribing, sometimes even punishing, worse than ever. We once had a patient who was whipped three times a day because he would not eat.

The parents' attitude toward the child must be entirely changed. They must be made to understand that the condition is aggravated by their anxiety and by the attention the child gains from this constant talking about his refusal to eat. It is better to have both parents present at the consultation so that there will be cooperation. If in the child's presence the parents disagree on the management, the condition is increased. It takes the wisdom of a Solomon and the earnestness of a preacher to persuade parents that their child will eat if properly managed. I usually start out by telling them that a large part of my new patients come with this worry. Then I tell them of an investigation which was made in three orphan asylums in New York City where anorexia was found in only two or three children out of a hundred. At this time I repeat Dr. Holt's dictum that it is not what one eats that counts,

but what one takes care of. Again, I ask if they have seen the fat person who eats so little and grows fatter; and the thin person who eats and eats and grows thinner. Your child does not need to eat what you think he should, I state, and if he enjoyed only a little food and had an appetite for that, he would gain and be well. I tell them that many of my patients who had anorexia during their early years become obese at puberty, and their parents then begged me to reduce their weight. I have many examples of this. Unfortunately, after much of this talk the mother will turn and say, "I know, doctor, but my child will simply not eat unless I force him."

The parents are told to be nonchalant toward the child's eating, and to tell the child that hereafter no one cares whether he eats or not. The food is to be served in the kitchen, and the child is told that his meal is ready. If he waits for thirty minutes without eating, the food is taken away and nothing further is said. In this way the child's negativism will be used against him because he then will eat to spite the mother. If this is carried out for two or three days, the hunger strike is usually overcome; but unfortunately only a few of our patients are willing to fast the child long enough. In this case the child should be separated from the family and sent to a hospital or, better, a nursery home in the country. I have two or three places where I can send these children to associate in a group and free from all the nagging of parents and relatives. These children do unusually well. Nothing is ever said about eating. They are brought to the table with the other children and are offered their food; and if they do not eat, they go about their routine without further question. The summer camps have been a great help, but in many camps the desire to put on weight has vitiated the training. These children, however, will revert back to their former condition if they are sent home too soon. The mother is usually sent for, and allowed to see the child eating from behind a screen. When we have convinced the mother that the child will eat, we let her sit with the child at table for several meals.

When Stafansson went to the North Land, he reported in his "Friendly Arctic" an interesting tale which has always influenced my

treatment of anorexia. At one time while living off the country he could obtain nothing but lean meat to eat, and he reports that his men and himself were always hungry. They would eat and eat, and still feel hungry despite the fact that their stomachs were distended. I have used this information in feeding where there is lack of appetite. We give a high protein diet without fat or carbohydrate. This is probably one reason why protein diets are so useful in celiac disease. If a young infant goes on a hunger strike, I put the baby on Dryco, which is partially skimmed dried milk, and the appetite usually returns in 24 or 48 hours. Skimmed milk is just as good, except that the mother dislikes to discard the cream. She will argue that the skimmed milk is not nutritious. In older children the same thing can be done with a greater variety of food. A diet of fat-free milk, meats, broth, gelatine, and pot cheese, leafy vegetables and stewed fruits without sugar, is used. A long interval between meals is prescribed. The child is fed at 7 a. m., 12 o'clock, and 6 p. m. with nothing between meals.

When unwanted food is forced upon children, it is retained in the stomach for long periods until it decomposes and irritates. There is a consequent excessive secretion of mucus, and the appetite becomes less and less. In some of our worst cases we wash the stomach at intervals of 24 to 48 hours until the return is free of retention and mucus. In the washings it is not unusual to find food taken over 24 hours before. There may be extreme amounts of mucus, and it is difficult to remove it unless a large tube and suction is employed. This treatment is usually objectionable to the parents, and cannot be used except where the child is placed in a hospital or nursery.

Another form of treatment which helps at present in institutions, and which may be very well used in private practice is the use of insulin. In our Convalescent Home in Portchester, Dr. Reginald Higgons has done a large series of injections in convalescents, and finds that it increases the appetite and increases growth greatly over the normal expectancy. There is so much prejudice against hyperdermic injections that I am afraid this would be difficult in the office.

HODGKIN'S DISEASE

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Abstract of an address given before the Monmouth County Medical Society, in Asbury Park, April 25, 1934

The speakers described some of the newer discoveries concerning Hodgkin's disease, showing x-rays, photographs, and photomicrographs. Their method of delivery was effective, each speaking for a few moments, while the other suggested questions for him to answer. The method gave each speaker time for reflection and to arrange his own ideas in logical sequence. An abstract of the address follows:

Hodgkin's disease is a definite clinical entity. Many years have passed since it has been confused with tuberculosis. We are convinced that it is a malignant neoplasm even though there are some who consider it inflammatory. Clinical diagnosis is of tremendous importance. The disease is frequently overlooked because the clinician does not think of the condition in the differential diagnosis.

Since irradiation is practically the only form of therapy, these cases are usually turned over, completely, to the radiologist by every department in the hospital. In this way he becomes responsible for the patients' general clinical care.

Hodgkin's disease is an incurable condition. The radiologist does not cure Hodgkin's disease; he manages it. The well-being and comfort of the patient depend on how well he carries out this management.

Several cases are being summarized. These cases were not selected because brilliant therapeutic results were obtained, but for their illustrative value.

CASE I

Female, age 28, referred to us with clinical diagnosis of pulmonary tuberculosis because presenting symptoms were persistent cough, fatiguability, and loss of weight of 8 to 10 pounds. X-ray examination showed a large tumor in the right lung which had originated at, or immediately above, the right lung root. The patient was treated with deep x-ray therapy (five daily treatments, receiving 100 r front and back of right thorax at each visit). Although regression was rapid, the patient still complained of marked weakness after several of these series of treatments. Generalized itching of the skin without any demonstrable skin lesion, fever of 100-101, and complaint of persistent fatiguability forced us to change our diagnosis from lympho-sarcoma to Hodg-

kin's disease. We, therefore, cut the dose of x-ray and altered the plan of treatment so that patient received only small doses (50 r) once or twice a week. Twenty months after we first saw this patient a biopsied lymph gland was diagnosed Hodgkin's disease. The patient died in less than 3 years and was autopsied. Our diagnosis was confirmed.

CASE II

Female, age 20, who complained of increasing weakness, cough, itching of skin and mass in right neck. A biopsy was done on mass in neck and diagnosis of lympho-sarcoma made. In addition, a large mediastinal tumor mass was discovered by x-ray of the chest. Despite the pathologist's diagnosis, the case was considered as Hodgkin's disease by us, and treated accordingly. Several months after we started treatment the entire case was reconsidered by our pathologist and the slides submitted to other medical centers. They agreed that it was Hodgkin's disease of thymic origin.

The patient is still under our care and is doing quite well. About twice a year she is confined to bed with an acute respiratory infection at which time the involved lymph glands become swollen to twice their normal size. They recede when the acute episode subsides. This tendency for the Hodgkin's masses to recur as a result of intercurrent infections is a prominent feature of many of our cases.

CASE III

A female, age 19, came to us with history of enlargement of glands of neck, axillae, and inguinal regions, and pronounced fatiguability. These symptoms had been present for the past 3 years. A biopsy of one of the neck glands was performed. The histologic section was quite characteristic of Hodgkin's disease. This case was presented to illustrate one of the unusual manifestations of the disease, namely, involvement of the breast. The breast was not involved when the patient was first seen, but was discovered during a "check-up" physical examination. In addition to the marked enlargement of the breast, nodular masses could be palpated in it. The masses disappeared and the breast became normal in size after several small doses of x-ray (50 r) at weekly intervals to it. This patient is still fairly well today (5½ years after onset of illness), but always

complains of extreme tiredness and at times has marked itching of the skin.

CASE IV

A woman, age 36, was referred to us with a clinical diagnosis of malaria. The patient had had chills and fever for two years prior to admission. The frequency of the attacks had increased from once a week to twice a day. The neck, axillary and inguinal glands were enlarged, as was the spleen. We were asked to give x-ray treatment to the enlarged spleen, in the hope that such therapy would drive malarial organisms into the circulating blood and enable the hematologist to corroborate the clinical diagnosis of malaria. After examination of the patient, Dr. Chamberlain made a clinical diagnosis of Hodgkin's disease, and insisted on a biopsy. The histologic sections substantiated his clinical diagnosis. Small doses of x-ray twice a week to the involved lymph glands and spleen produced a spectacular result. Within three weeks the patient, who had been desperately ill, was able to leave the hospital. She has been under our care for the past two and one-half years, and has remained so well that we have difficulty in getting her to come in for examinations at regular intervals. Like patients II and III, she is confined to her bed with an attack of grippe about twice a year. At this time the involved glands become markedly enlarged.

CASE V

This young woman, age 26, is known to have had a lung tumor for seven years. She complained of pain in the chest, dyspnea, loss of weight and night sweats. Various diagnosis, including encapsulated empyema, benign lung tumor, and dermoid cyst had been made. Dr. Chevalier Jackson found a compression stenosis of the right bronchus. The mucous membrane lining this bronchus was intensely inflamed and was covered by a cheesy secretion. Although there was no lymph adenopathy, a diagnosis of Hodgkin's disease was made because of the intense itching of the skin. Material obtained by needle biopsy was entirely consistent with the histologic picture of Hodgkin's disease.

The patient responded immediately to small doses of 50 r to the front and back of the thorax. The treatments were given at weekly

intervals. The tumor regressed promptly, and the individual stated that she felt well for the first time in seven years.

CASE VI

One of the few male patients in our series, age 37. The case was presented to show bone involvement, another site for this disease. It also demonstrates that surgery has no place in the treatment of Hodgkin's disease. Complete extirpation of the involved glands of the neck was followed in nine months by the occurrence of the rib tumor. The patient died within a year of the operation. An autopsy was performed.

The relationship of Hodgkin's disease to lympho-sarcoma and leukemia was discussed. These three conditions are grouped as lymphoblastoma by some workers, but we feel that Hodgkin's disease is a clinical entity.

The manifestations of Hodgkin's disease are many. This diagnosis should be thought of in patients exhibiting any one of the following conditions: weakness or unusual fatiguability, cervical, axillary or inguinal adenopathy, itching of the skin without demonstrable skin lesions, lung tumor, mediastinal tumor, unexplained fever, unexplained or unclassified anemia, splenomegaly, retroperitoneal or mesenteric tumors, certain types of bone destroying infiltrations and breast tumors of certain types.

In our series every patient has complained at some time or other of itching of the skin. All of them become fatigued easily. Each patient has had a fever of 100-101 for indefinite periods. Most of them have had lymph adenopathy throughout the course of the disease. Episodes of acute illness, which last about one week, are characterized by fever, malaise and marked swelling of the lymph glands. This swelling subsides when the patient recovers.

We feel that the diagnosis is not definitely established until biopsy is done. All of the cases were biopsied. Provided there is no accessible tissue for the usual biopsy, a needle biopsy should be performed. If this is impossible, the response of the tumor to small doses of x-ray should be determined. Rapid regression of the involved tissue to 50 r doses of x-ray strengthens greatly the clinical diagnosis of Hodgkin's disease.

PROBLEMS IN MEDICAL DIAGNOSIS

By ALFRED STENGEL, M.D.,

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Abstract of an address before the Atlantic County Medical Society on April 13, 1934, in Atlantic City, N. J.

Diagnosis, the recognition of the real underlying cause of the patient's symptoms is, of course, an essential preliminary to intelligent treatment. Diagnosis, however, contrary to an idea prevalent among the laity, not uncommon among young medical men, and encountered occasionally even in the older members of the profession, implies much more than simply *tagging* the disease with a label or a name. The important thing is, not that the patient has some particular disease which is recognized and can be named, but how does he react to it. In other words, how does this particular condition or abnormal stimulus act in his body so as to produce the symptoms of which he complains, and the manifestations of deviation from the normal which he presents?

We now recognize that, far more important than to name the disease, is to recognize that its manifestations represent the disturbances of bodily mechanisms and the activity of the body's defense reactions to individual and various environmental and external stimuli. It follows, therefore, that it is not the disease alone, but the disease as manifested in this particular and individual patient which must be the focus of treatment.

This concept is modified somewhat in specific infections arising from specific causes and for the treatment of which biologically specific agents are available—antitoxins, for example. Even here, however, the individuality of the patient is important because, as one of the earlier bacteriologists sapiently said: "It is not that the pneumococcus is specific for man. It is that certain individuals are specific for the pneumococcus."

Susceptibility to infection is of more importance in determining disease than the mere presence of an infective agent; and so we should be as much if not more interested in studying the reaction of the individual to infection as in studying the characteristics of the bacteria—for it is the reaction of the individual which determines the picture, the course, and the ultimate result of the infection in *his* body.

It is important to name the disease, when possible, if only for the important reason that the patient wants to know **what is the matter** with himself; but of far greater importance is it to recognize how he got the sickness.

Dr. Stengel illustrated his point with several case histories in which a succession of conditions, each carefully diagnosed and skillfully treated, afflicted the patient, but in which no appreciation was had and no attention paid to the fact that the reason these things occurred in the individual was because there was an underlying preparation for them based upon physical and nervous fatigue and exhaustion. This fatigue was the condition which should have been recognized and overcome—not the various labeled conditions which followed in its wake, and which, in the last analysis, were made possible only because of it.

The practice of medicine has passed through various eras, many of them characterized by what may be called bluntly *fads in treatment*. There was the era of ovariectomy, so to speak, as well as others, and we are now almost at the end of what might be called the *pathological era* characterized by emphasis laid upon the pathological lesion. The pathology of rheumatism, for example, was that it was a non-purulent inflammation of synovial membranes. Now, however, we do speak of rheumatic fever as a general infection without localizing it especially in joints. We are interested now, as we should be, in the *dynamic*, rather than the *static*, aspects of disease. We appreciate, for example, that the pancreas is the site of the lesion in diabetes, but what we want to know is, what varied backgrounds and mechanisms are responsible for the multitude of manifestations of diabetes? This, as yet, remains a problem awaiting an elucidation, which will come in time.

Commenting upon the many advances which have been made within the comparatively recent times with the resultant numerous additions to the physician's armamentarium, Dr. Stengel emphasized that we are, as it were, embarrassed with a wealth of knowledge. We have, for example, the bronchoscope, the cystoscope, the x-ray, and the multiple and varied facilities of the clinical laboratory, such as blood chemistry, serology and so on, all of which we are tempted to use in the examination of our patient.

It is important to bear in mind, however, that there exists practically no individual the study of whose body and its reactions by all

the varied means at our disposal will not show more or less abnormalities.

The point in question is to remember that the mere presence of an abnormality is not necessarily the final solution of the patient's diagnosis. There was, for example, the patient with the complaint of a persistent pain, and in whom the x-ray showed the presence of a renal calculus which was duly removed with the result that the patient's symptoms were sion of the spine. Instances such as these illustrate the necessity for careful evaluation of the findings, and equally meticulous care in the selection of what should be done to lay bare the underlying cause of the patient's reaction.

It is impossible to be right always; the physician is not and cannot be infallible. In the endeavor to be thorough there is often a temptation to do too much, especially as the doctor must sometimes strive to avoid the implied censure of those whose main comment is that this or that examination has not been made.

All facilities for making examinations are of great value, and all have their uses when wisely applied. The important thing is to employ them intelligently and discriminately; and having applied them, to be able to evaluate and interpret their significance in the particular situation at hand.

It is the indiscriminate use of these varied facilities which is often responsible for the complaint of the high cost of medical care. There is little excuse for using laboratory methods and laboratory facilities as a cloak for the ineptitude or laziness of the physician. In this connection, Dr. Stengel disagreed with the view that the family practitioner was disappearing. He felt that the family practitioner would always be the important factor in the handling of the patient; and this fact made it essential for him to keep in the fore-front of medical advance, and to familiarize himself with all that the modern practice of medicine implied.

Dr. Stengel felt that, while *group* practice was in principle an excellent thing, it could be a good thing in fact only when the group was efficient, and avoided the tendency to put patients through the "mill" because they had come to a group.

Passing on to a consideration of the importance of medical history of the patient, Dr. Stengel emphasized the utter futility of compiling merely statistical data as to what the patient had or had not had, and merely checking off various parts of his body as

presenting no change or various abnormalities. He criticised severely, and with justice, the taking of the history by other than the physician in actual charge of the case. While this practice is not uncommon, it is quite obvious that the lay clerk, the nurse, or the medical student cannot possibly be in position to have the varied and comprehensive outlook which is essential to the taking of a good history. The history is of the utmost value in the diagnosis of any condition; but it has its full value only when it is taken intelligently and well. It must not consist merely of a list of what has happened to the patient in the past, or the patient's interpretation of those happenings, and of what the patient thinks about them. Much more than that is required. The essence of many minutes of questioning may be set down in a sentence; but whether or not that sentence is of any value in the management of the case depends upon the intelligence with which the questions are selected, and the acumen with which the answers are interpreted.

A careful and comprehensive history should be followed by an equally careful and methodical physical examination before any decision is made regarding specialized investigations or laboratory studies. The physical examination, no matter how thorough, with an indifferent history may readily leave unsuspected many a hint of a deep-seated disorder that could be revealed by close questioning regarding the patient's past and present experiences and vice versa. Even the best of medical histories may fail to disclose facts which a complete physical examination will at once make clear. The combination of the two methods of approach constitute the real fundamental basis for diagnosis and this foundation must be laid before any superstructure of special investigations is added if we would avoid unnecessary, costly and time-consuming examinations.

A large proportion of medical conditions can be fully diagnosed if a full and accurate history and physical examination have been obtained and the physician who cultivates this method of diagnosis will widen his appreciation of the real "natural history" of disease and will develop his diagnostic acumen. For him the truly admirable adjuvants to diagnosis derived from the laboratories will become the means of solving otherwise inscrutable problems, but he will escape the enslavement of those who approach every medical diagnosis armed with a test tube and a microscope, and who are bound in time, while following this method, to suffer an atrophy of their powers of observation and reflection.

ABSTRACTS OF LOCAL MEDICAL SOCIETY PAPERS

ESSENTIALS OF TRAUMATIC SURGERY

By JOHN J. MOORHEAD, M.D.,

Professor of Clinical Surgery, Columbia University Post-Graduate Medical School

Abstract of a paper read before the Atlantic County Medical Society, March 9, 1934

As distinguished from general surgery, there is no incubation period in trauma which, emergency in origin, should be emergency in remedy. Hence, the first six hours after injury is the golden period for traumatic therapy, for there are then neither complications nor infection. The maximum of *initial* care is essential for the minimum of deformity and disability. Trauma requires a longer period of treatment than any other acute medical or surgical problem and, because of the frequent medico-legal and compensation aspects is more of a shared problem.

Trauma is a type of "on exhibition" surgery—for a limp with a bulging ankle cannot be hidden. Trauma requires more patient coöperation, and more coöperation from the patient, than other surgery—and is, as all know, a more fertile field for lawsuits, not least because traumatized tissue responds poorly to operative efforts.

Every traumatic wound is an *infected* wound, so that the essentials of the "golden period" in their treatment is the removal of foreign material and devitalized tissue. The best cleansing agent is soap and water copiously applied, plus gasoline for removal of grease or tar. Antiseptics should be used only as an adjunct and not as a substitute for soap and water. The best antiseptic is tincture of iodine, seven per cent. Debridement should be nonsacrificial, but thorough and drainage is essential. Gauze is not to be used ordinarily; and if used, it is to be vaselined or soaked in oil or other similar agent to prevent sticking. Sutures should be sparingly placed and not tied until the third day, the usual pyogenic organisms having run their cycle by then, their removal being aided by iodine-saline dressings during this period. Infected wounds should not be incised until the infection is localized; and then deeply enough to make the wound self-gaping. Open air, sunlight, and electric light are to be preferred in the granulation stage. Rest is essential during the presumptive infection period; motion is essential thereafter. Dressings should be left off above the neck level and, indeed, in any area where protection can be secured by frames, shields, or cellophane.

Tetanus antitoxin is almost always indicated and should be given slowly and in divided doses, in order to lessen the frequency and severity of reactions.

Burns are infected wounds due to heat, and have three phases; dermatitis, exudation, and granulation. The best dressing in the early stages is a five per cent solution bicarbonate of soda; and in the secretory stage, electric light or sunlight, with a protective dressing of olive oil and camphorated oil, equal parts. Tannic acid is also useful. Body

burns are best treated by light and without dressings, being protected by a frame. Dressings should be soaked off, and never pulled off. One of the best remedies for a burn is a large dose of opium; one of the worst, a dirty ointment or stale caron oil.

Fractures are either incised or non-displaced, or lacerated and displaced; and the object of treatment is to realign the fragments.

The four R's of the fracture and dislocation lexicon are: Recognition, Reduction, Retention, and Reconditioning. Think of fracture first and dislocation last. Reduction is either manual or mechanical, and should be done when the fracture occurs. Delay beyond six hours means complications. Every fracture or dislocation is set by setting, not the *bone*, but the *muscles*. Avoid temporary splints. Apply instead provisional traction, splintage, and the next day the overlapped fracture will be non-overlapped and require little further manipulation. Any dislocation can be reduced by traction and the exercise of patience. When this is not successful, suspect an associated fracture. Use anesthesia more often to set fractures or dislocations, but avoid chloroform.

Splints should be safe, simple, and secure. Make the splint to fit the patient, hence, use plaster of Paris slabs. Avoid circular casts which are "coffin casts", because they bury the fracture, and often the doctor's reputation.

Remove splints in sections when union is solid. Use angle iron projections or walking calipers so that leg and thigh cases may become ambulatory in days or weeks rather than months.

Reserve operations for those cases in which diligent use of closed methods fails, or where open correction gives best results. Skeletal traction is an excellent method. Plates, screws, etc., are passing into disuse.

Fractured skulls require operation for three reasons only: to elevate gross depressions; to remove blood clot; and when all other methods fail, to afford decompression. Fractured spine is often overlooked without an x-ray; and when unrelieved by closed correction, is rarely benefited by laminectomy.

Many non-overlapping and greenstick fractures require no reduction and are best left alone; if the normal carrying angle is maintained, the physician's duty is done.

Every compound fracture is a potential osteomyelitis. The maggot treatment of osteomyelitis is only once removed from advice to breed rats to get rid of garbage.

Deformity does not necessarily mean disability. Joint injuries demand mobilization, rather than

immobilization; and early, rather than late usage.

Aspiration is the sovereign remedy for synovitis.

As to the diagnosis, remember the slogan: "If the violence is adequate, expect and suspect an adequate effect."

There cannot be any two opinions with regard to the patient in shock. Only one should be thought of, and that is to treat the major situation first. If the shock is greater than the injury, treat the shock first.

The type of fractures of the skull which we see now are very different from those we used to see. I used pages and pages to narrate the types of injury we had in 1917 and in my newer edition of my book I cut it all out as we do not get those types any more.

There are three types of skull fractures which we get now:

(1) The ones who get well no matter what is done.

(2) Those who get well depending on what we do.

(3) Those who do not get well no matter what we do.

With the second group we can get rid of the three d's—death, deformity, and disability.

The interest in traumatic surgery is tremendous. There are ten major articles on that subject in the last issue of the *Annals of Surgery*.

Fifteen or twenty years ago we saw a number of cases of fat embolism, but I have not seen any in a long time. I have seen a mesenteric embolism recently in frost bite.

PUBLIC DISABILITY CASES

The accompanying schedule of fees is that recommended by the "Fee Committee" of the Staff of the Atlantic City Hospital and it is a schedule which under ordinary conditions we feel is fair to all parties concerned. It is based upon rates for semi-private ward patients and comparable to those fees charged in compensation cases.

A CASE OF TULAREMIA

By LOUIS A. SCHNEIDER, M.D., West New York, N. J.

Read before the Hudson County Medical Society, April 3, 1934

Tularemia is not an uncommon disease, but its occurrence in this locality is a rarity. The case presented by the speaker was the first case on record in Hudson County, and the third in the State of New Jersey. The disease is of practical interest because of an increasing number of cases developing in the Eastern States after inoculation from wild rabbits sold as food.

W. B., a white male, age 19, butcher's helper by occupation, was taken ill on January 1, 1934, with a severe chill, fever, headache, vomiting and prostration. At the same time, he complained of pain in his right axilla. He had been dressing rabbits during the Christmas holidays, and on December 27, he had received a laceration on his right index finger.

Examination: The patient was seen by Dr. Schneider at his home on January 2. The examination revealed a very acutely ill patient with a temperature of 104°, pulse 80, and respiration 20. There was a laceration about one-half inch long on the ventral aspect of the right index finger, over the second phalanx; and another at the ventral aspect of the left index finger at the base of the thumb. In both axillae there were enlarged lymph nodes about the size of a small walnut, and the one in the right axilla was tender. The remainder of the physical examination was essentially negative. In view of the history, he was sent to the hospital with a tentative diagnosis of tularemia. On admission, the laboratory work revealed a hemoglobin of 75 per cent; white blood count 5,200; 74 per cent polymorphonuclear leukocytes and 26 per cent lymphocytes. Urinalysis was negative.

First Week: The temperature during the first week fluctuated between 103.4° in the first day to normal on the seventh, with a pulse never above 100 and respiration normal. The Wassermann, B.

Melitensis, typhoid, para-typhoid, and a blood culture were negative. A blood specimen sent to Trenton was negative for *B. Tularensis*. At this time, examination of the patient revealed a generalized adenopathy; there were palpable nodes in the inguinal, axillary, epitrochlear and in the anterior and posterior cervical regions. Both axillary nodes were very tender.

During the second week, the patient's temperature gradually rose from normal until it was 103° on the fourteenth day.

An x-ray of the patient's chest at this time revealed a moderate lack of illumination in the left upper lung field, with a number of small scattered discrete calcified foci in both apices, suggesting an old healed tuberculous process. Solitary calcified lymph nodes in right hilum. Moderate thickening of hilum on left side. Findings point to general toxicity and an old healed tuberculous infection.

On the eighteenth day, another specimen was sent to Trenton, and at this time a specimen was sent to the United States Public Health Laboratories at Washington. The report from Trenton was negative, but the report from Washington came back positive in a dilution of 1:10; partial agglutination in a dilution of 1:40 and 1:80; and a request for another serum a week later. The white blood count on the fifteenth day was 16,800, with 49 per cent polymorphonuclear leukocytes and 51 per cent lymphocytes.

From the fifteenth to the twenty-first day, the patient's temperature fluctuated between 100 and 102°. There was no change in his condition except for the tenderness in both axillary lymph nodes, and at this time the right epitrochlear nodes became enlarged and painful. On the twenty-third

day, another specimen was sent to Washington and the report came back with a positive agglutination for *B. Tularenses* of 1:1280.

From the twenty-third day until the forty-second day, he ran a low-grade temperature of about 100°. At this time, the lymph nodes in his right axilla began to suppurate, and an incision was done, and about two ounces of pus were evacuated. On the seventy-third day of the patient's illness, the left axillary glands began to fluctuate and on incision about three ounces of pus were found. On the

eightieth day, the right epitrochlear glands also suppurated and had to be incised. Following this, the patient's temperature became normal.

On the ninety-second day of the patient's stay in the hospital, he was discharged. At this time the drainage from all his glands had stopped, and except for a secondary anemia and some malnutrition, his condition on discharge was good.

Treatment: The treatment in this case was entirely palliative, with the application of magnesium sulphate dressings to his tender nodes.

BLEEDING FROM BENIGN LESIONS DURING AND AFTER THE MENOPAUSE

By ARTHUR JOHN WALSCHEID, M.D., New York City and Union City, N. J.

Abstract of a paper read before the Hudson County Medical Society, April 3, 1934

Bleeding during and after the menopause is by no means always an indication of cancer of the uterus, although cancer must always be suspected until it has been definitely disproved.

The malignant lesions which may be responsible for menopausal or post-menopausal bleeding are, roughly speaking, cancer of the corpus uteri, cancer of the cervix, cancer of the vagina and vulva, and carcinoma or sarcoma of the ovary and fallopian tubes. These conditions, which are only incidentally mentioned in this paper, may be dismissed with the statement that they require the most careful investigation and the earliest and most radical treatment.

Among the benign lesions causing bleeding during and after the climacteric may be cited simple metropathia hemorrhagica, prolapse of the uterus, senile vaginitis, traumatic vaginitis from the use of pessaries and from other causes, fibroids of the uterus, hyperplasia of the endometrium, endometrial polyps, polyps of the cervix, cystic ovaries, large ovarian cysts, and twisting of the pedicle of an ovarian cyst. In addition, there are cases without any apparent local pathology where it may be necessary to regard constitutional factors, such as arteriosclerosis and hypertension, as playing a causative rôle.

Bleeding from any of these causes is very diverse in character; but there is no relationship between the type of bleeding and what may be found on examination. Bleeding around and after the climacteric must be regarded as a serious clinical sign, but it has little differential diagnostic value.

The easiest diagnosis of any pathology which disturbs the normal contour of the uterine cavity is by means of utero-salpingography. In cases where these diagnostic methods do not give conclusive proof, curettage and biopsy are demanded.

Dr. Walscheid discussed briefly a few of the most common conditions in menopausal and post-menopausal bleeding:

(1) Metropathia hemorrhagica is the simplest condition we have to deal with. It usually stops of itself when the menopause is fully established. It should be watched, however, for the possibility of development of carcinoma of the body of the uterus. There is no need of operation. It is only when this condition changes its character and

bleeding becomes profuse, and secondary anemia a factor, that treatment must be considered.

(2) Adenomatous or fibroadenomatous polyp of the cervix, one of the commoner visible lesions, occurs in about 10 to 15 per cent of the cases. Bleeding, which is not often profuse, is the sole symptom. The treatment consists of simple removal of the polyp, with or without postoperative radiation. Every polyp, like every other extirpated uterine growth, requires a biopsy.

(3) Fibromyomata of the uterus probably start growing before the menopause, but frequently do not come to attention until long after it is established. Uterine fibromyomata, like uterine polyps, often postpone the menopause until the age of 55 or beyond, and bleeding may appear as a menorrhagia. The easiest diagnosis of fibroid, either submucous or interstitial, is by utero-salpingography.

The treatment of fibroids depends on the local symptoms and conditions, and rather unfortunately on the preconceived ideas of the patient. Some women insist on irradiation, although the speaker does not consider this the method of choice when the fibroids have attained any size.

Recurrences after radium have been reported, and one must always consider the liability of future cancerous degeneration of fibroids or their remnants at this period of life. When hysterectomy is done, one feels relieved of the responsibility of uterine cancer.

(4) One of the most interesting conditions leading to irregular bleeding is hyperplasia of the endometrium. This may occur at practically any age after the onset of puberty; but, according to Novak, something like 20 per cent of the cases are seen between the years 45 to 49, and about 10 per cent in the years 50 to 54. The uterus is entirely normal except for the hyperplasia. Bleeding in these cases is apt to be profuse and secondary anemia an important factor, so that treatment cannot be delayed.

Hyperplasia of the endometrium, as seen in the extirpated uterus, shows varying degrees of grossly observable overgrowth. Sometimes the endometrium is quite smooth and not much thickened, while again the degree of hyperplasia may be very

great, and it may have reached the polypoid stage or fungoid endometrium.

Diagnosis in hyperplasia necessitates a curettage. In certain post-menopausal cases, this alone may stop the bleeding; but as a rule the ovarian function must be destroyed by more stringent methods, as a radium treatment or hysterectomy.

(5) An important cause of bleeding during and after the menopause is the uterine polyp, as distinguished from the cervical. A polyp is nothing more than a portion of endometrial tissue protruding into the cavity of the uterus. If the patient bleeds profusely and frequently has cramp-like uterine pain, diagnosis is made by inspection, palpation, utero-salpingography or the curette. In a great majority of cases, however, diagnosis is made only in the extirpated opened uterus.

(6) Ovarian tumors, with or without other pathology, may produce post-menopausal bleeding; and the same is true of an ovarian cyst of the twisting of the pedicle of a large ovarian cyst. Simpler causes than the above are ovarian cysts and systic ovaries.

(7) The vagina also may produce conditions leading to bleeding, as senile colpitis, and stenosis and atresia of the vagina and cervix, besides vaginal polyps.

(8) Cases of late bleeding, without local path-

ology, are rare. Some writers with large series of cases have stated that they found no cases which could not be accounted for without recourse to the more vague pathologies of venous stasis of the portal vein, affections of the heart or lungs, or vasomotor disturbances. However, these indeterminate pathologies, like hypertension from cardiac or liver diseases, cannot be disregarded. The speaker had a personal case in which the closest examination showed no local pathology, and curettage and microscopic examination were negative, but bleeding ceased on treatment for heart trouble.

Cardiac insufficiency or hypertension can bring about climacteric bleeding by producing a passive pelvic congestion. Regulating the heart with digitalis relieves the patient of bleeding. Curettage or endocrine therapy in these cases rarely avails.

Every case is entitled to the benefit of all necessary diagnostic aids. The apparently simple cases, those with non-malignant visible lesions, should be followed up to be certain that they show no masked malignant pathology. The indefinite case without apparent pathology may require much time and patience before a satisfactory diagnosis and therapy are found. Cases in which there is much mixed pathology, with tumors whose nature it has not been possible to determine, are better treated, all things considered, by hysterectomy than by irradiation or by attempts at local removal.

ANGINA PECTORIS

By JOSEPH WEINER, M.D.,

Cardiologist to the Monmouth Memorial Hospital

Abstract of a paper read before the Monmouth County Medical Society, January 24, 1934

In reviewing medical literature, one finds frequent references to conditions which certainly have been instances of what we now recognize as angina pectoris. Thanks are due to the remarkable study of Heberden in 1768, who established and identified the clinical aspects of this syndrome. This original study is one of the outstanding pieces of medical literature. It was Edward Jenner in 1799 who pointed out the frequent association of this syndrome with disease of the coronary arteries.

In 1821, an attempt was made to differentiate the angina pectoris of Heberden from closely simulating conditions which were referred to as "psuedo" or false angina—which differentiation still remains a difficult clinical problem. Fortunately, we are getting away from the expressions "pseudo angina" and "false angina". The clinical picture presenting itself either is, or is not, angina pectoris.

Certainly mental and emotional factors are all important in the production of this clinical picture. Not only may the attack be precipitated by emotional states, but also it will occur almost exclusively in persons of the emotional type. Frequently when self control is practiced, attacks may be diminished or minimized. Not only do disagreeable emotional stresses act as exciters of angina, but also pleasurable and agreeable experiences may, and do not infrequently, precipitate an attack.

There exists a general belief that hypertension and angina pectoris are closely related. It is some-

times difficult to persuade some that the absence of hypertension is no argument against a diagnosis of angina. Brooks reports a series of 350 cases in which 200 had a normal tension, 54 a hypotension, 96 a hypertension. It is true that the personality background of hypertension is fertile for the development of the anginal syndrome.

The most constant and most important symptom of angina pectoris is *pain*. Ordinarily the pain is severe, but the intensity varies not only in different cases, but in different attacks in the same patient.

During the seizure the patient is inarticulate; he stands fixed in his agony; he rarely moans or seeks to express in words or gestures his agony; his muscles are fixed in an apparent effort to limit pain; his skin is a gray pallor and covered with a cold sweat; and terror appears as a distinctive feature of the symptomatology.

Attacks may be unassociated with any definite cardiac disturbance. The pulse may be full and regular, the heart sounds may be normal apparently, but usually the pulse is small and the heart sounds weak. Electro-cardiograms may be normal; murmurs are rarely developed during an attack; blood pressure is usually lowered; and dyspnea is rarely seen.

Although the clinical picture of angina pectoris is consistent, there is no inflexible constant or certain pathological background for the symptom complex.

Many extracardiac conditions causing pain in the left chest are erroneously laid to the heart. Pardee lists many such states among which are osteoarthritis of the dorsal spine, mediastinal tumor, esophageal tumor, pleural adhesions, distention of colon, cholelithiasis and intercostal neuralgia. The error, however, is more frequently in the other direction. Prognosis is most difficult.

Treatment is by all odds the most important subject from the standpoint of the patient and the physician. It must be directed primarily, to the correction of the disturbed physiology and the underlying pathologic state. Consideration must be given to obesity, heredity factors, and endocrine imbalance; to adequate and controlled exercise; to avo-

cation habits affording proper outlet of emotional and nervous tension; and to the control of infections. Selection of life occupation should occasionally mean the well balanced intelligent interference of the family physician. All these are important factors in prophylaxis.

Treatment of the acute attack is paramount. It is imperative that the attack, no matter how mild, be checked promptly. Occasionally relief is obtained by the application of heat.

Nitrites are most efficacious and should be given early. Hypotension is no contraindication to the use of nitrites. The patient should always be permitted to rest as long as possible after an attack; and, if possible, sleep should be induced.

THE IRRITABLE BLADDER IN THE FEMALE

By GEORGE F. HOCH, M.D., New York City,

Urologist to St. Luke's Hospital and the Woman's Hospital

Abstract of a paper delivered March 15, 1934, before the Morris County Medical Society

The bladder has an internal circular and an external longitudinal layer of smooth muscle, not perfectly defined. The direction of these fibres and the number of layers into which they can be separated depends on the degree of distension of the bladder, rearranging themselves during changes in the size of the bladder.

In addition, we have the trigonal muscle, the fibres extending fanwise from the ureteral orifices, some fibres passing medially to form Merciers bar, others passing downward to the urethra making up Bells muscle. The trigonal muscle passes over the posterior border of the vesical orifice and spreads out as an internal longitudinal layer over the posterior aspect of the urethra. The fibres in the male pass between the openings of the prostatic ducts, ejaculatory ducts and for some distance past the veru montanum.

The external longitudinal layer of the bladder muscles from the base sweeps up over the vesical orifice, making a loop. Within this loop the circular layer forms a wedge below the orifice and flows down the urethra in an oblique direction surrounding the canal as a thin layer. The result is a double loop and not a sphincter. The vesical neck is opened by the contraction of these muscles, rather than by their relaxation.

There are many causes producing an irritable bladder. Infection of the urinary tract should be placed first. I say urinary tract advisedly, as cystitis *per se* is not an entity. Most infections of the bladder are secondary to an upper urinary tract infection—some from a remote focus; but rarely, if at all, due to instrumentation unaccompanied by trauma. Of the infections, tuberculosis of the urinary tract is the most troublesome in causing chronic disturbances.

Next is calculus disease. If a calculus is in the upper urinary tract, the accompanying infection causes inflammatory changes in the bladder. A

stone in the ureter properly canalized rarely gives symptoms; but if it is located in the intramural portion of the ureter, frequency and dysuria usually ensue. This we can explain by the pull on Bells muscle.

Next come new growths in the bladder.

Retention of urine in the female was considered an impossibility at one time, but it occurs frequently. Gynecologists have taken Cabot's advice that an overdistended bladder is the cause of post-operative infections, and have resorted to frequent post-operative catheterizations to prevent infection.

Extraneous causes may produce an irritable bladder. Diseases of the generative tract probably cause most. Diseases about the anus may also give rise to symptoms. One patient had a marked irritability which subsided only after a fistula in ano was corrected.

Allergic reactions, particularly with ephedrine and procaine, may give bladder symptoms.

Eye strain has also been mentioned as a cause for frequency. An ophthalmologist questioned all his patients as to frequency of urination, and after correcting their ocular disturbance, found in many that their frequency disappeared.

The most baffling patients are those who on cystoscopic examination show a thickened bladder mucosa with adherent mucus. There may or may not be ulcerations either multiple or single as in the Hunner type. The examination of the upper urinary tract is entirely negative, and no tubercle bacilli or other organisms can be found. This is the type to which the term *interstitial cystitis* is applied. It is probably of embolic origin. Urination occurs every thirty minutes to an hour, and suprapubic pain is almost constant.

The diagnosis of the irritable bladder requires a thorough cystoscopic study, including catheterization of the ureters, urography and pyelography either retrograde or excretory, a culture of the

separated urines, and a diligent search for tubercle bacilli and guinea pig inoculations. The urethra and the trigonum are especially to be observed.

The treatment depends on the cause. Infections of known origin are to be eliminated by local treatments, medication, diet, and fluids. In the local treatment instillations of argyrol, coagulation of ulcers or the use of acid nitrate of mercury. A quartz lamp is now made that can be used through a cystoscope for the ultra-violet radiation of the bladder.

For the papillitis occurring at the vesical neck topical applications of silver nitrate up to 10 per cent usually suffice. Many, however, need to be coagulated with the high frequency current.

The most bothersome cases are those with an interstitial cystitis. No one type of treatment is sufficient. Since most of these cases have tight urethrae, dilatation should be done. The ulcers respond well to coagulation. Removal of parts of the bladder gives only temporary relief. A careful search for a focal infection should be instituted and an autogenous vaccine has given relief in some cases.

There remains the resection of the presacral nerves. I have not felt the need for performing this on any of my patients; but when all other measures fail, I shall do so. It seems logical that it should relieve the pain, since it does so in pelvic pain from carcinoma.

LEADERSHIP BY PHYSICIANS

By ALBERT B. DAVIS, M.D., Camden, N. J.

Abstract of the address of the retiring President of the Camden County Medical Society, October 3, 1933

Life is a handicap race in which our individual handicaps are greater or less as the case may be, so that we do not all even get started as equals. We can't help that. But the wise provision of our fathers was that before the law one man should be treated as well as another, that there should be no privileged class, and that as far as humanly possible every individual in this nation should have full and free opportunity to make the most of himself and his life. This is the open road, the highway that in this country must ever be open from the humblest home to the very peaks of attainment—as witness Lincoln himself, from the log cabin of the railsplitter to the White House.

This is the ideal that typifies America. It includes, of course, the idea of live and let live, the square deal, and all that; but it goes much farther. It means that the way is open for every man to reach the greatest heights of self-development and attainment of which he is individually capable; and that as long as he strives ahead without injuring others, his road must be kept open as far as it is possible for government and the social order to do it.

It is the open road to the goal that stimulates the worthwhile individual to strong endeavor and high achievement. And so we have seen in this country a generally high level of individual achievement led and inspired by many strong men who singly or in groups have accomplished works of great public service, such as the building of our railroads, our telegraph and telephone lines, the founding and endowing of universities, schools and hospitals, the establishment of medical centers and research foundations—works so great that in other nations most of them have been done by government, and not nearly so well. As the whole is the sum of its parts and the nation the sum of its individual citizens, the political and social system that tends to the production of strong and happy individuals is better than the system that tends to stifle individual initiative and development in over-

organization and over-activity of government. And is this not our danger today? Indeed, I am afraid we have already traveled some distance on this road. Some good authorities think so.

Over-organization and over-activity of government are what we have to watch. Most of us here, during our own lives, have seen government, city, state, and national, expand from three to five-fold or more in all directions, especially that of cost. And it is our own fault. It is not the individual tyrant, either king or dictator, we need fear, but the continuous, insidious growth of a hydraheaded bureaucracy assuming to itself all power and all wisdom, willing and eager, with the help of all so-called "welfare" and other busybody organizations, to reach out and lay the "dead hand of government" on all the activities of its citizens. And it is our own fault if we allow this.

We must ever maintain our independence, our liberty of action, our privilege of solving our own problems. Already we have seen a government bureau set up to do medical work but headed by a layman, or perhaps I should say a lay-woman. Already we have seen a government commission, with a majority made up of laymen and institutionally-minded physicians, laying down a complete set of regulations for the whole medical profession. It is the trend of the times; it is in the air to centralize authority and to regulate everything. But if regulation is in the wind, let us by all means do it ourselves. Someone has said—

"One ship drives east, another drives west,

While the selfsame breezes blow;

'Tis the set of the sails, and not the gales,

That bids them where to go.

Like the winds of the air are the wars of the fates,

As we journey along through life;

'Tis the set of the soul that decides the goal,

And not the storm or the strife."

HEMORRHOIDS

By HOMER I. SILVERS, M.D., F.A.C.S., Atlantic City, N. J.

Abstract of a paper read before the Staff Meeting of the Atlantic City Hospital, July 10, 1933

The diagnosis of piles is made almost entirely by the history that the patient gives, plus a close visual inspection. This inspection can be accomplished if the patient is placed in a comfortable position on the table, with proper instruments and a good light. If the piles have become extruded and caught by the sphincter so that swelling rapidly occurs, or because of frequent prolapsing are irritated and infected, then they are readily recognized for what they are.

In most patients there is very little difficulty in passing the anoscope; but should there be any infection present, particularly in the presence of a fissure, the passing of any object through the anal canal becomes extremely difficult and painful and is often impossible. It then becomes necessary to overcome the sphincter spasm that is present, and that means to anesthetize the painful area.

As seen through the anoscope, internal piles do not always conform to their appearance when prolapsed, and not at all to their appearance when strangulated. It takes some little experience to place the proper value upon a moderate internal pile that is nonprolapsing. Probably the best position in which to place the patient while making an examination for hemorrhoids is the left lateral Sims position. This is a comfortable one, and allows inspection while the parts are in a normal state, and does not distort nor disturb the contiguous tissues.

The nomenclature of hemorrhoids has been somewhat confusing, but let it be remembered that two main classifications exist: internal and external; and that various other names are variations or continuations of these two.

Large varicose masses are frequently seen surrounding the external margin of the anus, and are the result of incompetence of the veins of the inferior hemorrhoidals. Bluish in color, increased in size by straining, these may distort the anal aperture and be the site of ulceration because of the inability of the patient to keep the parts clean. They are painless unless infected, or because of a rupture of one of the dilated veins, hemorrhage occurs with subsequent distension.

Internal hemorrhoids are the tumors that develop as the result of dilatation and degeneration of the veins derived from the superior and middle hemorrhoidal veins. They occur in the terminal three or

four centimeters of the bowel and are limited distally by the pectinate line. Mucous membrane covers them, and if the protruding mass has in part tegmentary covering, then they must be referred to as of the mixed variety.

Internal hemorrhoids are so common that a large proportion of the population would show this affliction if they were called for an examination. Being situated in the bowel where pain sense is poor, the presence of small piles would pass without notice. It is when they attain size, become infected, or when protrusion occurs, often associated with strangulation, that recognition is made.

Bleeding is one symptom that will always lead a patient to make his diagnosis of piles; and while it is a very common symptom associated with hemorrhoids, it must never be accepted as such until investigation proves by elimination that the piles are the sole source of bleeding.

Treatment by injection has of recent years sprung into considerable recognition, and in certain types of cases offers much.

In America, about 1870, the treatment of piles by injection began in Central Illinois, and was quickly seized upon by itinerant "quacks". As a result, it was not looked upon with favor by the medical profession, for being performed in a "haphazard" and uncleanly manner, disastrously destructive results were often obtained.

Injection of hemorrhoids today is upon a much surer basis and is looked upon by proctologists as a valuable procedure. There should not be any conflict as to whether hemorrhoids should be operated upon or injected, but rather that which suits the particular problem presented. Operation is still the best method of removing the offending piles, but injection offers to the individual who will not consider operation an opportunity for relief that he would not otherwise have. It is also a method of treatment for those individuals whose physical condition would render any operative procedure hazardous. Likewise, it is safe to inject hemorrhoids during pregnancy.

Not all hemorrhoids should be subjected to injection. Probably not more than 50 or 60 per cent are the type that respond favorably to injection, or in which injection may be safely attempted. Unless injection can be done safely and easily, and the patient go comfortably about his work, it is more advisable to operate than to inject.

MECHOLIN FOR TACHYCARDIA

The closing paragraph of the article on Ectopic Paroxysmal Tachycardia in this Journal of June, 1934, page 349, by Dr. John Wyckoff, of New York City, should read as follows, according to a note received from the doctor:

Recently mecholin (acetyl-beta-methylcholin) has been found to stop a great majority of attacks of

supra ventricular tachycardia when given subcutaneously. If the drug alone will not stop the attack, the drug in combination with carotid pressure is almost sure to do so. The usual efficacious dosage is 50 milligrams.

The only change is substitution of the word *subcutaneously* for intravenously.

EARLY DIAGNOSIS AND TREATMENT OF CANCER OF THE FEMALE PELVIC ORGANS

By W. P. HEALY, M.D., New York City,
Gynecologist, Memorial Hospital

Abstract of a paper read before the Atlantic County Medical Society, May 11, 1934

Dr. Healy prefaced his remarks by commenting upon the changes which have occurred in the practice of medicine. It is not so very long ago, for example, since great emphasis was laid upon typhoid fever, then a prevalent disease. Now epidemics are infrequent and cases scattered and relatively uncommon. This is true also of many other infectious diseases, once common, now infrequent, and even the infections of childhood, such as diphtheria and scarlet fever are gradually coming under control.

Now the emphasis is all upon the degenerative types of disease such as cancer, although, of course, infections of various kinds still occur. Cancer, and cardio-renal disease are now the chief causes of death.

Some, perhaps, might feel that cancer is being over-emphasized, and become impatient at the somewhat discouraging results obtained, but success in the management of cancer demands that the doctor first of all be cancer-minded, that he must recognize the vital importance of early diagnosis and early treatment. When he adopts this attitude he will be less pessimistic and realize that much can be done for these patients, not only in the way of symptomatic relief but also in the prolongation of life.

After these prefatory remarks, the slides were shown presenting first, the results of partial and complete vulvectomy with or without accompanying radiation in carcinoma of the vulva.

For melanoma of the vulva little can be done except through surgery as these tumors are not radiosensitive. One case was shown occurring in a girl of 15, later dying with extensive metastasis.

Leukoplakia of the cervix, while not malignant, is decidedly a precancerous lesion not to be neglected. The squamous cell metaplastic type of lesion is also important but easily destroyed by cautery and excision.

From 94 to 96 per cent of cervical carcinomata are seen in women who have had children, so that there is evidently some relation between the trauma incident to childbirth and the later development of malignancy, which emphasizes the necessity for careful post-delivery examinations and the appropriate treatment of such lesions as a prophylactic measure against malignancy. This cannot be over-emphasized. The erosions, lacerations and other injuries often seen several months after delivery are easily cured in the office if seen and treated *then*. If they are allowed to progress because neglected or unrecognized they are an important factor in the development of cervical malignancy.

The largest number of such growths are the squamous cell carcinoma types which, if seen early, furnish a large number of 5 year arrests or "cures". They are most common between 48-49 years of age and, unfortunately, are often symptomless until the appearance of blood when not anticipated. This is explained by their structure as demonstrated by the slides.

The three types of cervical carcinoma are: 1. The adult type of squamous cell, resistant to radiation. 2. The type showing a more definite architectural structure, with many mitotic figures. These are more radiation sensitive. 3. The structure is somewhat suggestive of melanoma but lacks the pigment. These are more embryonal in type and respond well to radiation. This type is very destructive and metastasize rapidly.

The treatment of cervical carcinoma in most cases should be by radiation by roentgen ray, and radium, as at least 80 per cent have necrosing ulcerative lesions.

From 4 to 6 weeks later radium needles can be implanted to complete the treatment. Not over 10 per cent of cases require interstitial radiation.

Carcinoma in the cervical stump is rare and cannot be regarded as primary unless seen within three years after hysterectomy. The mortality is greater than when the uterus is still present.

Corpus carcinoma is more frequent after than before the menopause. The papillary type of adenocarcinoma can be completely removed by curettage, nothing being seen when the uterus is later removed. Hysterectomy cures in 100 per cent.

Adenoma malignum is common in myomatous uteri after the menopause and 95-100 per cent can be cured by surgery and radium.

The massive, infiltrating type of adenocarcinoma spreads rapidly and only 50 per cent of cases can be saved for five years. This group is best removed from the surgical class and treated by radiation alone.

Ovarian tumors are surgical lesions. One in four will be malignant; all respond to surgery, followed by deep roentgen therapy.

Radiation will cause the complete disappearance of the very cellular embryonal type of tumor in young women.

It should not be forgotten that, even in the hopeless case, much can be done to improve the comfort of the patient by dietary regulation, sedatives, and morphine.

Slides showing diagrammatically the plan of treatment followed at the Memorial Hospital, as well as the tabulated results in 2600 cases, completed the presentation.

STATE SOCIETY ACTIVITIES

REPORT OF DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

By JOHN F. HAGERTY, M.D.,

Chairman of the New Jersey Delegation

The 85th annual session of the American Medical Association is now a matter of history. It was well organized and well attended, about 6500 having registered. The weather was well-nigh perfect, and the commercial and scientific exhibits, together with the papers and discussions at the various section meetings will afford abundant material for reading and reflection for a long time to come.

The meetings of the House of Delegates were especially interesting this year because of the many problems having to do with the economic side of medicine which were considered. Because of the acute interest in these problems a preliminary report of the work of the House is being submitted by your delegates. Lest such a report might prove unsatisfactory, a general review of the matters considered will be made in a supplementary report.

At the first session the effect of economic pressure was shown in the Secretary's report, to the effect that the number of Fellows had been reduced nearly 2000 during the past year, and "in most instances resignations were based on an expressed desire to be relieved of the payment of Fellowship dues and subscriptions because of the unfavorable economic situation." The Board of Trustees, approved by the House of Delegates, had already shown its sympathy with the above situation by retaining on the roster all Fellows who indicated their intention to remit within a specified time. This same desire to be of assistance to the profession in its struggle against present-day tendencies harmful to the interests of the profession was shown by its attitude toward the many problems presented.

President Bierring and retiring President Lewis reiterated their opposition, and that of the House of Delegates, to the hospitalization of veterans for nonservice-connected disabilities, and especially to the latest feature of the Act—acceptance of declaration of disability upon statement by the applicant for relief.

Resolutions opposing radio advertising of drugs, medicines and appliances, and offering to cooperate with the Federal Radio Commission in creating a central national bureau to advise as to what is proper advertising on these subjects, were adopted.

Also the resolution of the Medical Society of the District of Columbia, condemning the

extension of free government medical services to high federal officials, cabinet officers, senators, representatives, public employees, their domestic servants and their families, was strongly supported.

A resolution making it mandatory that all physicians on staffs of hospitals approved by the Council on Medical Education and Hospitals be Fellows of the American Medical Association, was adopted, after some discussion.

The principal interest centered about the resolutions concerning Health Insurance, introduced by the Michigan State Medical Society. This resulted in the formation of a committee of seven members, with Dr. N. B. Van Etten, of New York, as Chairman. This committee brought in the following report, which was unanimously adopted. It is a declaration of principles for guidance of the Association in considering any proposed change in the nature of practice.

The points were:

1. All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control.

2. No third party must be permitted to come between the patient and his physician in any medical relation. All responsibility for the character of medical service must be borne by the profession.

3. Patients must have absolute freedom to choose a legally qualified doctor of medicine who will serve them from among all those qualified to practice and who are willing to give service.

4. The method of giving the service must retain a permanent, confidential relation between the patient and a "family physician". This relation must be the fundamental and dominating feature of any system.

5. All medical phases of all institutions involved in the medical service should be under professional control, it being understood that hospital service and medical service should be considered separately. These institutions are but expansions of the equipment of the physician. He is the only one whom the laws of all nations recognize as competent to use them in the delivery of service. The medical profession alone can determine the adequacy and

character of such institutions. Their value depends on their operation according to medical standards.

6. However the cost of medical service may be distributed, the immediate cost should be borne by the patient able to pay at the time the service is rendered.

7. Medical service must have no connection with any cash benefits.

8. Any form of medical service should include within its scope all qualified physicians of the locality covered by its operation who wish to give service under the conditions established.

9. Systems for the relief of low income classes should be limited strictly to those below the "comfort level" standard of incomes.

10. There should be no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession.

Two resolutions were introduced at the request of our own State Society. The first, referring to violations of the Pure Food and Drug Act and expressing dissatisfaction with the Tugwell bill, was referred to the Board of Trustees. It might be said here that this Board at the meeting in June, 1933, after a careful study of the Tugwell bill, adopted the following resolution:

Whereas, The American Medical Association has for years protested against the inadequacy of the National Food and Drugs Act of 1906, because of which inadequacy the officers of the government charged with the enforcement of the act have been and are unable effectively to protect the people against fraud and danger to health; be it

Resolved, That the American Medical Association pledges its support toward procuring the formulation and enactment of effective national food and drug legislation adequate for the protection of the people.

The second resolution, asking consideration by the House for the principles contained in

the address of President Quigley, was referred to the Board of Trustees.

General discussion on the subject of Socialized Medicine followed, during which the New Jersey delegates made an appeal for earnest consideration of the resolutions introduced by them. It seemed to be the opinion of the House that the conclusions of Dr. Van Etten's committee covered the matter adequately.

Resolutions introduced at the request of the Michigan State Society, asking for creation of a committee of five to advise doctors and laymen concerning materials and methods of birth control and the conditions that justify their employment were tabled by a decisive rising vote.

This is the fourth time that these resolutions have been introduced, and each time the proposals have been rejected.

Perhaps the most important decision arrived at, and far-reaching in its effects, was that of the Board of Trustees for a re-survey of medical schools in the United States, having in mind their reduction in number and thereby securing reduction in the proportion of physicians to the population. Should such a plan be carried out, it will have a material influence on the economic status of the profession.

Another pleasing announcement is that the Convention will be held in Atlantic City next year, where those who are interested may attend the various scientific sections and all may visit the splendid scientific exhibits which each year constitutes one of the best features of the meeting.

Sessions of House of Delegates are open to all Fellows.

(Signed) JOHN F. HAGERTY, M.D.,
WALT P. CONAWAY, M.D.,
EPHRAIM R. MULFORD, M.D.,
PHILIP MARVEL, M.D.,

Delegates.

The New England Journal of Medicine of June 21, 1934, has an editorial on the meeting of the American Medical Association. Commenting on the New Jersey resolutions on the leadership of the A. M. A., the New England Journal says:

"The feeling expressed by the President of the New Jersey Society at the last annual meeting of that society to the effect that the Amer-

ican Medical Association has been disinclined to formulate policies, has been endorsed in some quarters, and justifies independent study and action even by members of the A. M. A. Although the great power and creditable accomplishments of the A. M. A. are recognized, the attitude of criticism of honest attempts to clarify some of the great problems before the country has not been conducive to harmony."

THE PHYSICIANS' LIEN LAW

To put the Physicians' Lien Act into operation is an immediate problem with which The Medical Society of New Jersey has to deal. Before any physician can establish a claim under the new law, county societies, county judges, and county clerks must perform certain duties which are outlined in The Journal of June, page 350. Leadership and coordination in the preparatory work are supplied by the State Society through the special committee of which Dr. Elmer Peter Weigel, of Union County, is Chairman. This committee has acted with promptness and efficiency, and has made a report to the House of Delegates, as follows:

"Your Committee appointed to study the Doctors' Lien Law (Senate Bill No. 136) has given much thought and time to its various provisions. We have prepared a suggested schedule of fees. We have also drawn a form to be used in filing our liens, and formulated letters transmitting the lien both to the Clerk of the Court and to the defendant. (Journal, June, page 353.)

"We have been approached by representatives of the insurance carriers assuring us of their desire to cooperate in the smooth functioning of the Law, but as yet we have not furnished them with a copy of the proposed fee schedule.

"We have also been approached by representatives of several legal organizations with offers of handling these liens for us, but it is our thought for the present at least, that we had best file our liens individually.

"It was our first thought that the fees should be quite moderate so as not to arouse too much opposition to their adoption. We believed that they will be attacked by both the legal profession and the insurance carriers, and felt that by holding them quite reasonable there would be less cause for criticism. It might be argued that whatever we received from the average liability case would be more than we have been getting in the past.

"I think many of us have come to consider these cases as being worth about as much as a similar compensation case. We feel, however, that these cases should be considered from a different viewpoint. They are potentially private patients. Compensation fees have been set by law and are administered by a referee, and we have no voice in establishing their amount. Fees for liability cases will be contingent upon the patient eventually getting a judgment against the defendant, and the in turn being financially able to meet that judgment.

"The various county societies as representatives of organized medicine in each county are compelled by this law to state what the proper fee shall be for each type of operation or treatment in that county. Are we prepared and willing to so commit ourselves?

"We have prepared our list with a minimum and maximum charge for each treatment; and yet, if my judgment is correct, the minimum fee will soon become the established fee.

"I think we are all agreed that in private practice fees are based very largely upon the skill, experience and reputation of the physician or surgeon involved. I see no way in which any of these factors can be given consideration under a pre-arranged fee schedule such as we are asked to submit.

"What will be the effect of such a fee schedule on our private practice? What will be our answer to the private patient, who may be well able to pay more for his care when he asks why his bill is higher than the amount agreed upon by the county society?

"Is it not possible also that some of us may be compelled to sue for collection of a bill, not necessarily in a liability case, and find that the amount is considered unreasonable if it is in excess of that mentioned in this fee schedule?

"These are some of the points which your Committee would like to have discussed by members of the House of Delegates.

"Respectfully submitted,

ELMER PETER WEIGEL, *Chairman,*
Plainfield, N. J."

The Reference Committee of the House of Delegates, to which the recommendations of the Committee were referred, reported as follows:

"This Committee has given careful study to the Act, especially to its provision that a fee scale be established, without having reached any final conclusion. Inasmuch as the fee scale before adoption must be approved by the Court, after the various interested parties—that is, the medical profession, the insurance carriers and the bar association—have been heard, we recommend that the Committee be continued, and that it be instructed to endeavor to reach an acceptable fee scale by joint agreement in conference with representatives of the insurance carriers and the Bar Association, and to report by or before July 1st, 1934, to the Board of Trustees of The Medical Society of New Jersey, who shall be empowered to decide the fee scale for The Medical Society of New Jersey."

On June 24 the Committee made a detailed report to the Board of Trustees, which approved its work and methods, and authorized its continuance as a Special Committee to report directly to the Trustees.

The State Committee is now engaged in conferences with the New Jersey Bar Association, and representatives of insurance companies in regard to the establishment of a fee list.

The first duty of every county society is to appoint a committee, similar to that of the State Society, whose duty is to see that the steps prescribed by the Law are carried out promptly, and with regard for similar action by other counties.

DISTRIBUTION OF FREE BIOLOGICALS

By J. LYNN MAHAFFEY, M.D.,

Director of Health, New Jersey State Department of Health

Free distribution of diphtheria toxoid and smallpox vaccine purchased with State funds, a project which has aroused the interest of physicians and health officials in New Jersey during recent months, is now a reality.

The program in which these biologicals will be used aims to secure a greater proportion of immunization among children below school age, and also the immunization of children in doctors' offices rather than in public clinics. This project was proposed by the State Medical Society early in the winter and reached its present form through the coöperative efforts of the Society and the State Department of Health. The latter is charged with administration of the project by the act of the Legislature which authorized the free distribution of the biologicals and appropriated funds for this purpose.

Rules under which the free materials will be supplied to physicians have been prepared by the Department, as required by the Act. In substance, the rules provide that a physician, in order to obtain the biologicals, must set apart a stated time at least twice a month, during which he will administer the toxoid and vaccine at a fee of one dollar a treatment, or without charge if in his opinion the parents of the child are unable to pay a fee. The toxoid is to be administered only to children between the ages of six months and ten years.

A physician who obtains the toxoid or vaccine will agree to report his use of the material upon a simple form furnished by the Department on a stamped, addressed post-card. (An alternate form for reporting ten toxoid treatments and five vaccinations on one sheet may be used.)

The willingness of the medical profession to make such reports promptly and fully is essential to the success of the project. There are three reasons why such reports are necessary.

1. The State Department of Health must account for the use of these public funds.

2. Complete and dependable records have always been available in the past of immunizations performed at public clinics. Any system which aims to displace such clinics must afford equally dependable records.

3. A project such as this, designed to secure state-wide protection of children against disease, is so extensive that only by a system of records can it be carried on in a satisfactory way. The record system established includes a check on the materials from the time they

are ordered from the manufacturer to the report of the physician of his use of the package supplied to him. Yet so simple is the system that little effort is required of the doctors or the local distributors of the biologicals in carrying out their parts of the undertaking.

Biologicals to be supplied include two-dose toxoid in a 10 c.c. package for the complete treatment of five children, one-dose alum precipitated toxoid in a 5 c.c. package for the treatment of ten children, and vaccine in a 5-point package. All packages are marked "Distributed Free by the State of New Jersey, Department of Health. *Not to Be Sold.*" In the northern part of the State, Squibb's products will be supplied; and in the southern part, those of the National Drug Co.

Distribution will be from stations located about the State at points as convenient as practicable for physicians. Stations have been set up in nearly all the counties except Essex and Hudson. These stations are listed at the end of this article. In Essex and Hudson Counties, free biologicals are being furnished by several local health departments. This situation requires that careful study be made in placing the state biologicals to avoid confusion and overlapping of service. Perhaps by the date this report is published the State supplies will be available also in these two counties.

The importance of physicians being familiar with the project as a whole and particularly their part in it, is self-evident. To insure this, a letter has been sent to each medical practitioner in the State whose name appears on the Department's mailing list, explaining in detail how and where the biologicals may be obtained and his responsibility in accepting them for use. A copy of the rules, an agreement form and the receipt and report forms which the physician will need may be obtained at any distributing station or by writing the Department at Trenton.

The rules adopted are as follows:

Information Concerning the Distribution and Use of Biologicals Furnished Free by the New Jersey State Department of Health

Diphtheria toxoid and smallpox vaccine are furnished free by the State to physicians who conform to Rules adopted by the State Department of Health for the distribution of these prophylactic biologicals.

The materials can be procured by physicians at distributing stations designated by the State Health Department.

A form of agreement which a physician may sign in order to obtain such materials may be had at any distributing station.

Any physician, having agreed to conform to the Rules, may secure the biologicals at stations by signing receipts for materials obtained.

State materials may be used only during the special hours or periods designated by the physician in accordance with the Rules.

A physician is expected to apply for not more than one package of each material at a time unless he has definite use for additional materials.

Toxoid is restricted for use on children from six months to ten years old.

Reports of the use of all materials obtained from the State supply must be made promptly on forms provided at distributing stations.

Pursuant to authority contained in Chapter 127, Public Laws 1934, and in accord with a plan for immunizations proposed by the Medical Society of New Jersey, the following Rules for distribution of free biologicals were adopted by the State Department of Health on June 5, 1934:

RULES FOR THE FREE DISTRIBUTION OF DIPHTHERIA TOXOID AND SMALLPOX VACCINE BY THE STATE DEPARTMENT OF HEALTH

1. The biologicals may be procured without charge by any physician licensed to practice medicine in New Jersey, at any distributing station arranged for by the Director of Health, provided such physician agrees to the following conditions:

a. The physician shall fix an hour or special period to be at least twice in each month at which times he will administer diphtheria immunization treatments to all children between the ages of six months and ten years, who come during such special hours, and will vaccinate against smallpox all who apply for such vaccination during the special hours, at a maximum charge of one dollar per injection or vaccination and without charge in the case of any one who, in the opinion of said physician, is unable to pay for such services.

b. Notification shall be given the Director of Health of New Jersey of the time and place of such special hours fixed by the physician and of any change in such hours; the state hours selected, together with the name and address of the physician, and the purpose of such special hours may be made publicly known by the State Department of Health or any local health department or other health agency.

c. Promptly after completing smallpox vaccination or administering a course of diphtheria immunizing injections with material furnished by the State, the physician shall forward to the State Department of Health, at Trenton, or elsewhere if so requested by the Director of Health, a report on a form furnished by the Department, showing the name, age, sex, color and place of residence of the person treated, together with the date or dates of treatment, the kind of material used and whether the service was performed for a fee or without charge. In the case of smallpox vaccination such report shall also state whether the vaccination was successful.

2. Biologicals furnished any physician shall be for his use upon residents of New Jersey during the special periods selected by him in accordance with Rule 1 (a) and in conformity with the provisions of said Rule.

3. Diphtheria immunizing material and smallpox vaccine furnished shall be kept in a refrigerator in which the temperature shall be between 32° and 50° F.

4. Biologicals furnished shall be utilized with due care to prevent unnecessary wastage.

5. A receipt on a form furnished by the State Department of Health shall be signed and left with the distributing agency at any time any biologicals are obtained.

6. The State Department of Health and any officer or agent thereof, shall not be responsible for any accident nor ill effects which may be ascribed to the use of biologicals furnished.

7. Failure on the part of a physician to comply with any of the Rules set forth above, or proof that a physician is not rendering service to those unable to pay as set forth in Rule 1 (a), or is unjust in determining ability to pay for such services, will be deemed sufficient cause to debar such physician from receiving free biologicals from the State.

NOTES AND RECOMMENDATIONS

Materials furnished—Diphtheria toxoid, 10-dose package; diphtheria toxoid (alum precipitated), 10-dose package; smallpox vaccine, 5 points package. Single-dose packages are not supplied.

Refrigeration—These biologicals must be kept at a temperature between 32° F. and 50° F. to retain potency.

Best age for giving toxoid—To young children, and preferably between the ages of six months and one year.

Choice of preparation—Toxoid (2-dose type) is recommended for all children from six months to ten years. An interval of at least two weeks should elapse between doses. If toxoid (alum precipitated) is selected, it is recommended its use be confined to pre-school age children.

Dosage—In all instances follow the recommendations of the manufacturer accurately.

Injections—Into subcutaneous or muscular tissue, near insertion of the deltoid or the triceps muscles.

Skin sterilization—For toxoids—Tincture of iodine to be allowed to dry before injection; after injection, stain may be removed with alcohol to prevent blistering.

Shaking Vials—If toxoid (alum precipitated) is used, shake vial *thoroughly* before *each* withdrawal of material. Preferably withdraw only one dose at a time.

Syringes—For toxoid (2-dose type) a syringe of not over 5 c.c. in size, gauged to measure accurately, is preferable. For toxoid (alum precipitated) a smaller syringe is preferable inasmuch as a single dose only should be drawn into the syringe at one time, to insure even suspension of the precipitate and thereby an even dosage.

Sterilization of Syringes—Boiling or immersion in alcohol. Syringe should be cooled and all traces of

alcohol removed before filling with material for injection.

Needles—Size—For either type of toxoid: No larger than $\frac{5}{8}$ inch, 25 gauge.

Sterilization of Needles—Same as for syringes, but when several injections are given with the same needle, it must be sterilized before each injection; wiping the needle with a pledget of cotton saturated with alcohol has proved satisfactory for this purpose.

Puncturing Bottle Tops—When only part of the contents of a vial is to be removed, the rubber cap should first be swabbed with alcohol and a sterile needle used to withdraw the contents into the syringe.

Schick Test—A few children are not completely immunized against diphtheria by the usual dosage of toxoid. Therefore, a Schick Test is advisable three months or more after toxoid is given to identify those children who require additional injections. To give Schick Tests, a small syringe with a $\frac{1}{4}$ inch, 27 gauge needle having a sharp "short bevel" point is most satisfactory. Final reading should be made 3-5 days after test if control is used; 4-5 days if without control. Schick Test material is not supplied free by the State.

The stations at which the biologicals are now available are as follows:

Atlantic County

Office, Board of Health, City Hall, Atlantic City
Somers Point Hospital, Somers Point

Bergen County

Bergen County Isolation Hospital, Paramus
Hackensack Hospital, Hackensack
Englewood Hospital, Englewood
Holy Name Hospital, Teaneck

Burlington County

Burlington County Hospital, Mt. Holly

Camden County

Camden City Board of Health Office, City Hall, Camden
Camden Municipal Hospital Laboratory, Sheridan Street, Camden

Cape May County

Office, County Executive Nurse, County Bldg., Cape May Court House

Cumberland County

Newcomb Hospital, Vineland
Bridgeton Hospital, Irving Avenue, Bridgeton
Millville Hospital, Millville

Gloucester County

Underwood Hospital, Broad Street and Red Bank Avenue, Woodbury

Mercer County

Office, Board of Health, City Hall, Trenton
Office, Board of Health, National Bank Bldg., Princeton

Middlesex County

Office, Board of Health, New Brunswick
Office, Board of Health, Perth Amboy

Monmouth County

Asbury Park Board of Health Office, Asbury Avenue and Main Street, Asbury Park
Long Branch City Board of Health Office, City Hall, Long Branch
State District Health Office, Court House, Freehold

Morris County

Office, Board of Health, Morristown
Office, Board of Health, Dover
Ward's Pharmacy, Butler

Ocean County

Office, Board of Health, Lakewood Township, Municipal Bldg., Lakewood
Point Pleasant Hospital, Point Pleasant
Ocean County Health Association, Court House, Toms River

Passaic County

Office, Board of Health, Passaic

Salem County

Salem County Memorial Hospital, Salem

Somerset County

Somerset Hospital, Somerville

Sussex County

Alexander Lynn Hospital, Sussex
Newton Memorial Hospital, Newton

Union County

Office, Board of Health, Plainfield
Office, Board of Health, Summit

County Society Reports

CAPE MAY COUNTY

Eugene Way, M.D., Reporter

The semi-annual meeting of the *Cape May County Medical Society* was held on Tuesday, May 15, 1934, at 11:30 a. m. at the Ocean City Golf Club, Somers Point, N. J.

The following members were present: Drs. Brooks, Corson, Crowe, Cryder, Dandois, Friedland, Gandy, Haines, Hughes, Monosson, Pettitt, Robbins, Townsend, Tomlin, C. W. Way and E. Way.

The President stated that Dr. Margaret Mace, of North Wildwood, was critically ill with pneumonia, and Dr. Oscar Ziegler, of Wildwood, with appendicitis.

The State Medical Society was represented by Dr. Frederic J. Quigley, Dr. LeRoy A. Wilkes, Executive Secretary; Dr. J. B. Morrison, Secretary; Dr. Frank Overton, Editor of The Journal; and Dr. Norman B. Tooker, from the Department of Operations of the New Jersey Emergency Relief Administration. Drs. Darnell, Conaway and Davis were present from the Atlantic City Hospital, and Drs. Marvel and Addiscott from the Atlantic Shores Hospital.

Delegates from the Cumberland County Society were Drs. Butcher and Myatt; from Gloucester County, Drs. Campbell and Diverty; and from Atlantic County, Drs. Fish and Madden. Drs. Pressman, of Woodbine; Friel, of Ocean City; and Mr. Alfred Cooper, Chairman of the E. R. A. of Cape May County, were also present.

The meeting was called to order by President W. D. Robbins. Col. C. M. Gandy, Chairman of the Board of Censors, reported favorably on the recommendation of Dr. Abraham Pressman, of Woodbine, for membership, and he was elected by a unanimous vote. Other applications were deferred until a future meeting.

The President stated that Dr. Julius Way, Chairman of the Committee on Welfare, Public Health, and Legislation, had asked to be relieved from the chairmanship of this committee, and that he had appointed Dr. A. C. Crowe in his place. He also stated that present economic conditions seemed to warrant the breaking up of this committee and forming three distinct committees in its place, but action would not be taken until the next meeting.

Dr. G. F. Dandois moved that Dr. William A. Darnell, of Atlantic City, be placed in nomination for Second Vice-President of the State Medical Society at the June meeting. Motion seconded and carried by a unanimous vote.

President Robbins stated that a vote of thanks be extended to Senator Read and Assemblyman Hunt for the efficient work done by them in behalf of the medical profession of the state. On motion, this suggestion was adopted by a unanimous vote. The President then introduced Mr. Alfred Cooper, of Cape May Court House, Vice-Chairman of E. R. A. for Cape May County, who gave an account of the work accomplished in the County, and favored the prompt payment of doctors' bills. Mr. Cooper then introduced Dr. Norman B. Tooker, from the Emergency Relief administration of New

Jersey, who gave a comprehensive account of the workings of the system and regretted that no pay was allowed physicians for treating contagious diseases. Discussion was entered into by most of the physicians present, but no satisfactory plan could be suggested for the many incongruities that appear in the administration of the E. R. A. code.

Dr. Frederic J. Quigley, President of The Medical Society of New Jersey, was then introduced and gave a pleasing address on the progress made in medicine in the state, with special mention of the excellent work of Drs. Crowe, Robbins and others in the Cape May County Society. Dr. Quigley was voted the thanks of the Society.

Dr. LeRoy A. Wilkes, Executive Secretary of the State Society, requested the profession to read the May Journal for work accomplished by the various County Societies in accordance with the projects of the State Society.

Dr. J. B. Morrison, Secretary of the State Society, discussed the question of dues, stating that the present dues of \$13.00 could not be reduced and the present work of the Society be carried out.

Dr. Morrison also spoke on the need of vaccination, and immunization, and stated that provision should be made for the payment of physicians for their work. The discussion was entered into by Drs. Myatt, Hughes, Dandois, Crowe, Corson and others.

Dr. Frank Overton, Editor of The Journal of The Medical Society of New Jersey, gave an interesting talk on The Journal, and thanked the reporters of the County Societies for their cooperation.

On motion of Dr. Corson, it was voted to hold a special meeting of the Society within the next thirty days to discuss the various economic conditions now confronting the profession, the exact time and place to be left to the President.

MIDDLESEX COUNTY

G. F. Hilker, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held at Pfaff's Restaurant, Metuchen, New Jersey, on May 23, 1934, with 35 members present.

The minutes of the previous meeting were read and approved. The following communications were read:

1. A scale of fees to be charged in connection with the Doctors' Lien Law is to be decided by each county and submitted to the State Society before any further action is taken. This was referred to the Executive Committee.

2. The list of school physicians who were restored to participation under the E. R. A. was read.

3. Excerpts from the report of the Sub-Committee on Hospitals of the State Society Medical Education Committee were read and discussed, and criticism of some of the suggestions was expressed. The delegates to the State Society were instructed to protest against the adoption of the plans which were criticized.

The following reports were then received:

Dr. Rowland, reporting for the Medical Educa-

tion Committee, gave a list of recommendations for future Post-Graduate Courses. He stated that the county members should decide what course they want, and recommended that next year the Medical Education Committee be larger and composed of about ten men from all parts of the county with a balance of older practitioners and younger doctors.

Dr. Moletch, reporting on the combined meeting of the Medical and Dental Societies at Jamesburg, gave the proposed date of the meeting as June 20th at 1 p. m. A luncheon will be served and entertainment provided for the doctors and their wives. All the doctors were requested to answer their invitations promptly.

Mr. Ambruster, present as a guest, gave an enlightening talk on the non-enforcement of the Pure Food and Drug Act. He asked that the doctors do not support the proposed Tugwell-Copeland Bill as it is a piece of emasculated legislation providing no criminal action against violators of the Food and Drug Act. He also showed instances of favoritism to the large manufacturer of drugs that had been declared unfit, yet their names were not published in the Journal of the American Medical Society while violators of lesser prestige were widely publicized by the J. A. M. A. This matter was referred to the Public Health Committee for action.

The guest speaker, Dr. Frederick M. Allen, gave an interesting talk on diabetes, showing the wide range of treatment that could be used, depending on the individual. He stressed the keeping of the blood sugar at normal figures all the time as a prophylactic against the complications of diabetes. After the discussion of the paper, a light luncheon was served and the meeting was adjourned.

Joint Meeting, Medical and Dental Societies

Edward F. Klein, M.D., Secretary

A joint session of the *Middlesex County Medical Society* and the *Middlesex County Dental Society* was held at the State Home for Boys, Jamesburg, New Jersey, on Wednesday, June 20th, 1934.

The purpose of the meeting was to bring about a closer association between the Medical and Dental practitioners and to get a first-hand knowledge of the work being accomplished at Jamesburg.

A luncheon was served the doctors and their wives at 1 p. m., following which addresses were made by Dr. Mark, President of the County Medical Society, and Dr. Symanski, President of the County Dental Society. The State Societies were represented by Drs. Ely, Quigley and Snider, as well as by Commissioner of Institutions and Agencies, Dr. Ellis, and Dr. Potter.

The Middlesex County Medical Society was praised during the addresses for the splendid work it has accomplished in conjunction with the E. R. A.

A remarkable sextet composed of members of the institution entertained the societies with negro spirituals.

A tour of inspection was held, in the course of which the fine buildings were visited and the excellent work being done for juvenile delinquents at Jamesburg was fully explained.

The serious side of the meeting being over, the

featured baseball game took place between the medical men and the dentists, with a final score of 10-6 in favor of the medical men.

MONMOUTH COUNTY

S. Edelson, M.D., Reporter

The monthly meeting of the *Monmouth County Medical Society* was held at the Fitkin Memorial Hospital on May 23, 1934.

The following report of the Executive Committee was read by the Secretary.

A meeting of the Executive Committee of the Monmouth County Medical Society was held at the Monmouth Memorial Hospital, Long Branch, on Monday evening, May 14, with the following members present: President Dr. John E. Maher, Drs. Parry, Watkins, Altschul, Gosling, Fairbanks, MacKenzie, Blaisdell, Nichols, Fisher, Herrman, Rullman and Featherston.

The Executive Committee hereby recommends the following change in the Constitution and By-Laws. This announcement is to be considered a written notification as required in the Constitution. The amended form shall read—"By Laws: Chapter III, Sec. 6. The Board of Censors five (5) in number shall be elected for a period of three years. The Senior member shall act as Chairman of the Board. The membership of this Committee shall be geographically distributed throughout the County. Etc."

A special committee was appointed by Dr. John E. Maher to draw up a fee schedule, as required by the Physicians' Lien Bill which was recently passed. The subject is considered important and the work difficult enough to necessitate a special committee. The men appointed are: Drs. Herrman, Chairman; Moffat, Parry, Hoiters, Blaisdell, Fisher, Reynolds, Pietri, Maher, and Featherston.

A report was made of a meeting of several members of the Executive Committee with the E. R. A. officials from Newark. As a result of this meeting, a better interpretation of the medical agreement was impressed upon the civil authorities and an increase in the number of initial calls allowed on the E. R. A. authorization was accomplished. Mrs. Louis Bodman, the County Director, has written to all the municipal directors in an effort to give them our interpretation of some of the controverted clauses in the medical agreement.

At this same meeting, Dr. Tooker of the State E. R. A. office, took a very decided stand against us in the matter of the treatment of E. R. A. cases in hospital clinics. It is believed that this condition could be remedied by making it necessary for the patient to obtain authorization of some sort for clinic treatment. Under the present arrangement, we feel that the patient prefers to receive clinic treatment rather than go to the trouble of procuring the necessary authorization for treatment by a private physician. Therefore, it is felt that if the same amount of routine is required for both means of treatment, the patient would probably prefer to be treated by a private physician.

Upon motion of Dr. O. K. Parry, seconded by Dr. Watkins, it was moved and carried that the Secretary write to Dr. Harry R. North, of Trenton, Chairman of the Budget and Finance Committee, and state that in the opinion of the Monmouth

County Medical Society no reduction in the State dues should be considered for next year.

The Secretary was also instructed to write letters of thanks to Dr. Blase Cole, of Newton, and Dr. Marcus W. Newcomb, of Browns Mills, for their efforts in the passage of the Physicians' Lien Bill.

A letter was received from the Monmouth County Organization for Social Service calling our attention to the procedure necessary for the admission of a patient to the Allenwood Sanatorium. First—a diagnosis of tuberculosis must be made and then the application blank must be filled out and signed by a doctor. The blanks may be obtained from the County Adjustor's office, or the County Supervising Tuberculosis Nurse at 131 Pearl Street, Red Bank, or at the Allenwood Sanatorium. A public health nurse will be glad to assist the family in filling out this blank and making any other arrangements necessary for admission to the institution. It is further stated that four days from the date of application is the usual length of time for admission to the institution.

A letter was received by Dr. R. E. Watkins from the Monmouth County Organization for Social Service concerning the care of State Board wards. After a discussion, it was recommended by Dr. Nichols that the doctors in Monmouth County agree to care for State wards for the following fees: Office call, \$1.00; house call, \$2.00 plus a mileage charge for over three miles; and surgery, x-ray and other specialties at one-half the usual fee. These charges are to be paid by the State Board of Children's Guardians.

Dr. W. G. Herrman, Chairman of the Economic Committee, reported that after an investigation of the plan for financing medical bills offered by the Monmouth Service Company, official approval could not be given for the Medical Society, but members could have agreements individually. The Economic Committee, therefore, recommends that no agreement with this company be entered into by the Society as a whole.

After a discussion of the large volume of clinic work which is being done by the doctors in Monmouth County, the following set of rules are submitted for the approval of the Society before attempting to enter into an agreement with the hospital authorities:

- "1. Clinics are for indigents only.
- "2. Clinics shall render emergency treatment to all persons applying for the same.
- "3. Clinics shall continue to treat only patients referred by a doctor, the reference to be in writing and attached to the clinic record of the patient.
- "4. Poormasters and nurses may refer cases to the clinics through the local physicians only.
- "5. Patients given emergency treatment shall be referred to their family physician, who may treat them himself or return them to the clinic with a note for admission.
- "6. A doctor sending a case to a special clinic, i. e., skin clinic, orthopedic clinic, etc., and wishing to continue the general care of the patient himself, should designate on the slip sent with the patient that he should be admitted to, for example, skin clinic only, orthopedic clinic only, etc.; then

the clinic shall refuse this case treatment in its other departments unless the doctor sends another note.

"7. Cases treated in accident rooms of hospitals may be referred to their family physicians, and for one visit to the surgical clinic. On the visit to the clinic the case will be checked and the hospital will be cleared of responsibility.

"8. Ward cases. When a case is discharged from the hospital ward, a postal card shall be sent to the doctor referring the case, notifying him that the patient has been discharged.

"9. Patients referred to follow-up clinics are to be given no treatment without written consent of the family physician, except for the condition treated previously in the hospital.

"10. Patients referred to clinics for diagnosis shall be returned to the family physician for treatment unless otherwise specified on the reference slip.

"11. All clinic work shall be done by regular or junior members of the Monmouth County Medical Society only.

"The term 'family physician' means the regular medical attendant of the family. If the patient has no medical attendant, the term should be interpreted as meaning the last physician to treat the patient in the past five years. Patients who are new residents with no physician shall be given the names of the doctors in the town in which they reside.

"The doctors doing clinic work may check on the method of a patient's admission to the clinics; but they shall treat the patient the first time and report any irregularity to the director of the clinic and the Secretary of the Monmouth County Medical Society.

"Any doctor engaging in work in a clinic that does not conform to the above rules shall be subject to expulsion from the Monmouth County Medical Society.

"Constructive criticism is welcomed."

The recommendations of the Executive Committee were approved by the Society:

Dr. Marc Krohn, Belford, N. J., was admitted to membership.

The applications of Dr. Edwin G. Dewis, Asbury Park; Dr. C. C. Perrine, Fair Haven, and Dr. J. F. Carter, Asbury Park, for membership were referred to the censors.

Dr. Morris Grossman, of Asbury Park and New York, read a paper entitled "Neurologic Problems in General Practice". The paper is enclosed for publication. —(?)

MONMOUTH MEMORIAL HOSPITAL CLINICAL CONFERENCE

The regular monthly conference of the Staff was held Wednesday, June 13, 1934.

Surgical Service:

1. Tubal pregnancy: tubal abortion; operation; recovery.
2. Ruptured urinary bladder; operation; patient doing well to date.
3. Hemolytic streptococcus septicemia.

Medical Service:

1. Rheumatic fever; pleurisy with effusion; rheumatic carditis. At this point the question of rheumatic peritonitis came up and the subject was discussed by Dr. Alfred Fischer.
2. Encephalitis with certain unusual features.

Pediatric Service:

1. Tetany in a very young infant.

Obstetrical Service:

Three case of hydrocephalus.

FITKIN MEMORIAL HOSPITAL CLINICAL CONFERENCE
JUNE 17, 1934

1. Typhoid fever, eight cases. Discussion of source of infection. Discussion of treatment including serum, treatment as advocated by Schwartzman.
2. Pyelonephritis.
3. Arterio-sclerotic heart disease.
4. Brain tumor.
5. Coronary thrombosis.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A regular quarterly meeting of the *Morris County Medical Society* was held the evening of Thursday, June 21, at the State Hospital at Greystone Park, with President Frost presiding over an attendance of about 45 members and guests.

Routine transactions included approval of minutes of meetings of the society held March 15, March 27, April 19, and May 17. The proceedings of the Executive Committee meeting of June 18 also were approved; these including reference to the favorable impressions of the Summit Medical Society of the programs put on by our society and requesting that advance bulletins of meetings and subjects be sent to them, which was granted; also that a new health ordinance had been submitted to the Board of Aldermen of Morristown and adopted by that body.

Dr. B. C. McMahon as a delegate to the annual meeting of the State Society, June 5-7, 1934, made a detailed report on the operations of the Nominating Committee and the election results.

President Inglis F. Frost, a member of the committee on the Physicians' Lien Law, described the work the committee had done in compiling a list of operations and the minimum and maximum fees. He said that a meeting is planned to be held on this subject at the Academy of Medicine in Newark, with representatives of the Bar Associations and the Insurance Companies; and that the schedule of fees to be recommended and submitted for approval may be expected at the September meeting of this society.

Dr. G. H. Lathrope of the Nominating Committee presented a roster of officers and delegates for this society for next year, to be voted on at the annual meeting in September, as follows: For President, Bernard C. McMahon; Vice-President, William F. Costello; Secretary, Albert J. Ward; Treasurer, George J. Young; Reporter, Marcus A. Curry; Historian, H. W. Kice. Additional members of the Executive Committee: Frank H. Pinckney, Inglis F. Frost and Henry M. Larson. Members of the

House of Delegates of the State Society, to serve for three years, Byron G. Sherman, R. L. Gilbertson; Alternate delegates, D. W. Teller and Stanley Teskey.

In making up these recommendations, Dr. Lathrope said that the Nominating Committee gave a good deal of consideration to the standpoint that they felt that in the next two or three years is going to come up more acutely the question of the economic condition of medicine, which has been rapidly forging to the front of late years; and they felt it extremely important to our society to have men in leadership and on the Executive Committee who have been thoroughly in the "know" of what is going on.

Dr. S. C. Haven, of the Tuberculosis Advisory Committee, made a most favorable report on the operations of the demonstration school survey conducted under the guidance of the committee by the County Tuberculosis Association; detailing the educational campaign among the parents, the Parent-Teacher Associations, and the pupils, the examinations, x-rays, etc., done, and stressing that the Association was endeavoring to direct this work back to the family physician, and that the Association deserves great credit for putting on this campaign and for their cooperation with the committee. On this the following action was taken unanimously:

"The Secretary of this society is hereby requested to write to the Morris County Tuberculosis Association that the Morris County Medical Society approves of this campaign and the manner in which it has been conducted."

The following new members were unanimously elected: Dr. J. A. Byrne, of Morristown, and Dr. S. H. Pink, of Butler.

Dr. Elvira Dean Abell spoke on the cards that had been sent to members in reference to the "Public Health Hour," urging their prompt return and explaining the plan for obtaining the vaccines and materials for this work, which soon will be available through local Boards of Health.

The feature of the evening was an address by Dr. John W. Hartwell, Director of the New York Academy of Medicine, on "The Problem of Medical Practice". The speaker said that New Jersey was ideally situated to grapple with the problem of trends in medical practice, for it is influenced by emotional viewpoints to less degree than many other states. It is futile for doctors to argue that the care of the sick is their concern, and theirs alone, for the laity is equally interested and intensely active in demanding efficient medical service for all.

Dr. Hartwell concluded by outlining an insurance plan.

Dr. Frederick T. VanBuren, Jr., Professor of Clinical Surgery and former Dean of the College of Physicians and Surgeons of Columbia University, very interestingly opened the discussion, and in this was joined by Drs. Lathrope, Costello, Haven, Pinckney, Curry, and others; after which the speaker of the evening answered various questions asked.

The very interesting evening concluded with refreshments in the hospital cafeteria.

Woman's Auxiliary

Essex County

Reported by Mrs. H. Alton Hastings Schachter

The regular annual meeting of the Woman's Auxiliary to the Essex County Medical Society was held at the Academy of Medicine, 91 Lincoln Park, Newark, on the afternoon of Monday, May 28, 1934, following a luncheon attended by the executive board of the Woman's Auxiliary, at the Hotel Douglas. Mrs. Norma Bingham, of the Newark Evening News, who was the guest speaker, gave an entertaining and vivid talk on the need for understanding and tolerance in a metropolitan city, such as Newark is.

Mrs. Frank McCauley, retiring President, was presented with the President's pin. The following officers were elected:

President, Mrs. Don A. Epler.

President-Elect, Mrs. K. C. Forsythe.

Vice-President, Mrs. Hunter Scott.

Treasurer, Mrs. H. J. F. Wallhauser.

Recording Secretary, Mrs. Charles Rathgeber.

Corresponding Secretary, Mrs. Charles Rich.

Directors: Mrs. William Crecca, Mrs. Charles Rich, Mrs. H. Alton Hastings Schachter, Mrs. Gus Braun, Mrs. William J. Donahue and Mrs. M. B. Weinstock.

There was a large and enthusiastic meeting, which was followed by a tea and social hour.

Passaic County

Reported by Mrs. Edward Leonard

The Woman's Auxiliary to the Passaic County Medical Society held a Public Health Meeting at

the Paterson Woman's Club on March 10th. The literary program had been arranged by Mrs. Orville R. Hagen, Chairman of the Public Health Committee.

Dr. Julius Levy, Director of the Division of Child Hygiene of the Board of Health of Newark, was the principal speaker; his subject being "The Health of the Pre-School Child". The meeting was well attended and proved very interesting and enlightening. Lantern slides were used to illustrate Dr. Levy's subjects.

On March 20th the Passaic County Medical Auxiliary held its regular meeting at the Passaic Y. W. C. A. Mrs. William A. Dwycer, President, presided.

The speaker on this occasion was Dr. Elmer Halbeck, principal of Public School No. 12 in Passaic. His topic was "Parent-Teachers Associations" and was a follow-up to the discussion of the care of the pre-school child which took place at an earlier meeting.

Plans were made for the annual luncheon meeting, which will be held on May 21st with Mrs. B. W. Bothyl in charge of arrangements.

The President appointed a nominating committee composed of Mrs. H. Nye, Chairman; Mrs. James Phelps and Mrs. James LoMauro, of Passaic.

Following the business meeting the members were the guests of Mrs. James LoMauro and Mrs. William Contrell at tea.

The peculiar field of the Woman's Auxiliary of New Jersey is that of interesting the ladies of the doctors' families in the activities of their husbands and fathers.

The usual plan is that the women hold their meetings at the same hour and place that the doctors hold theirs. While many auxiliaries hold scientific sessions, the meetings are always social events which bring the ladies to-

gether, and reveal their common difficulties and aspirations. An auxiliary will have done a commendable work if it leads to the encouragement and support of the physicians in their daily routine of visiting sick folks. A comparison of notes by the ladies leads them into sympathy toward the doctors' hobbies, which are restoratives of the nervous energy and sharpeners of their powers of perception.

Obituary

LESTER H. HUMMEL, M.D.

Dr. Lester H. Hummel, of Salem, died on June 6, 1934, at his home on East Broadway, following an illness of several weeks. He was born in Shiloh sixty-one years ago. He attended the old Shiloh Academy and also the South Jersey Institute, Bridgeton. He was graduated from the Baltimore Medical College, and took an extra course in children's diseases at Baltimore and in surgery in Philadelphia. Later he had perfected himself in electrical work, his offices being modernly equipped.

His first practice was in Greenwich, Cumberland County, and after being there for seven or eight years he moved to Salem and had been located there about thirty years.

He was for some time on the Medical and Surgical Staff of the Salem County Memorial Hospital. He served on the Board of Education and also the Board of Health, and was a Mason.

He leaves two sons who are physicians, Dr. Lee G. Hummel, of Salem, and Dr. Merwin Hummel, of Merchantville; and also a brother, Dr. E. G. Hummel, who practices medicine in Camden.

Communications

FREE DRUGS FOR VENEREAL DISEASES

Many physicians are treating patients with gonorrhea and syphilis who cannot pay any fee or, at best, a very small fee. In the treatment of syphilis rather costly drugs must be used. To assist physicians who are treating persons dangerous to the public health, the State Department of Health during the present emergency will supply some drugs. The physician need only include, with the report of his case to the State Department of Health a statement that the patient is indigent and infectious. The patient may be considered indigent if the physician does not receive more than \$2.00 per visit nor more than \$2.00 per week from this patient. There will be sent to him promptly the following supplies:

For syphilis:

- 10 ampoules of neoarsphenamine 0.6 gm.
- 10 ampoules of distilled water
- 1 bottle (30 c.c.) of bismuth subsalicylate.

Or for gonorrhea (male):

- Urethral syringe
- 30 silver lactate tablets.

Or for gonorrhea (female):

- 40 vaginal capsules and acriflavine tablets.

In some instances, the local board of health is willing to pay the physician a small fee for such services in accordance with the requirements of the venereal disease law. This law makes it the duty of the local board of health to provide treatment for any person suffering from a venereal disease in the infectious stage who makes application for such treatment and is, in fact, unable to pay. However, there is a large class of people who have always been self-supporting and who would rather discontinue treatment than appeal for help. The attending physician continues to serve them. Such physicians are urged to ask freely for drugs.

In accordance with the plan adopted several years ago, drugs are sent also whenever the source of infection is given on a report of a case of syphilis or gonorrhea. In such a case, the drugs are sent without regard to the patient's ability to pay and without any specific request from the physician. It is an honorarium to the physician for information which in many cases is secured only after tedious and patient questioning.

Information as to the source of infection is very valuable in preventing the further spread of disease. The name and address of the source of infection is sent to the local health officer, who is authorized by law to investigate suspected persons and to require examination and treatment. The physician's name and the name of the patient, of course, are held strictly confidential by the State Department of Health.

A. J. Casselman, M.D., Dr. P.H.,
New Jersey State Department of Health

1934 GRADUATE FORTNIGHT OF THE NEW YORK ACADEMY OF MEDICINE

The Seventh Annual Graduate Fortnight of The New York Academy of Medicine will be devoted to a consideration of gastrointestinal diseases. The Fortnight will be held October 22 to November 2.

Sixteen important hospitals of the city will present coördinated afternoon clinics and clinical demonstrations. At the evening meetings prominent clinicians from various parts of the country who are recognized authorities in their special lines of work will discuss the various aspects of the general subject.

A comprehensive exhibit of anatomical, bacteriological and pathological specimens and research material will be shown. Many of the exhibits will be demonstrated.

Among the subjects to be presented at the evening meetings and in the hospital programs will be:

General principles involved in the diagnosis of gastrointestinal diseases, medical, surgical, roentgenological.

Constipation.

Diarrhea.

Physiology of the gastrointestinal tract.

Diseases of the pancreas, especially acute pancreatitis and its treatment.

Diseases of the esophagus.

Functional diseases of the stomach.

Disorders of the gastrointestinal tract in children: infections, management, surgery in infants and children.

Diet in relation to gastrointestinal diseases in infancy.

Clinical examination of the patient from the surgeons' and the internists' points of view.

Demonstrations of diets used in treatment.

Peptic ulcer—Medical discussion, surgical discussion.

Carcinoma of the stomach.

Chronic lesions in the paracecal region.

Acute appendicitis.

Peritonitis.

Gall-bladder, and biliary passages—Medical discussion, surgical discussion.

Jaundice.

Tumors of the colon.

Diseases of the rectum, including tumors.

Intestinal obstruction.

Diverticulitis.

Colitis, amebiasis, functional disturbances of the colon including mucous colitis.

Hirschsprung's disease.

Lymphogranulomata.

Clinical methods and differential diagnosis.

Technic of the gastrointestinal series.

Laboratory examinations.

The profession generally is invited to attend. A complete program and registration blank may be secured by addressing: Dr. Frederick P. Reynolds, The New York Academy of Medicine, 2 East 103rd Street, New York City.

For the Comfort of Your Patients ---

Items listed may be had on Monthly Rental Basis

INVALID BEDS

FRACTURE BEDS

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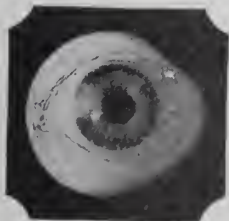
The June number of *California and Western Medicine* contains the record of the annual meeting of the California Medical Association, which was held in Riverside April 30 and 31, 1934. A resolution was introduced favoring "the organization of an insurance corporation under the laws of the State of California, to provide hospital service, and if the Council so determines, to defray the cost of said limited medical service to patients while hospitalized.

The outline of the proposed plan fills a page of the Journal, and was debated at length. The action taken was as follows:

"That this committee shall be instructed to conduct an adequate study and survey of the problem as it applies to California and to formulate a plan for the administration of health insurance and to prepare a bill for suitable legislation which may be available for presentation in the 1935 session of the California State Legislature."

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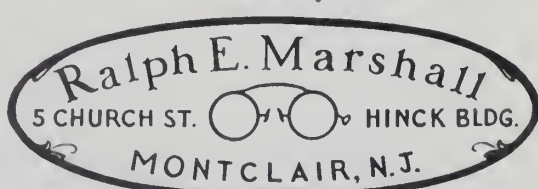
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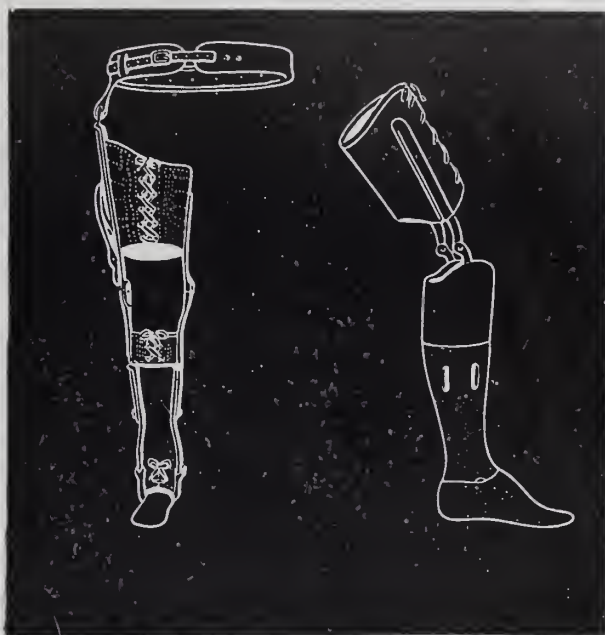
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A safe, dependable form of creosote which sensitive stomachs tolerate. It is actually creosote, loosely combined with hydrated calcium oxide.

Calcreose is supplied in tablet form, each tablet Calcreose 4 grs. equivalent to two minims of pure creosote.

At Leading Prescription

Pharmacies

Sample to Physicians

on Request

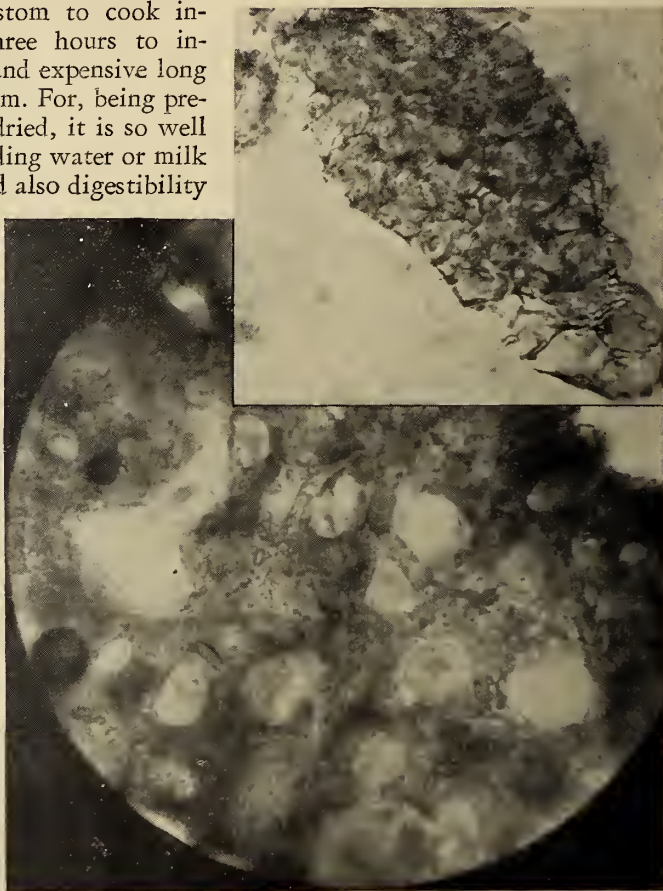
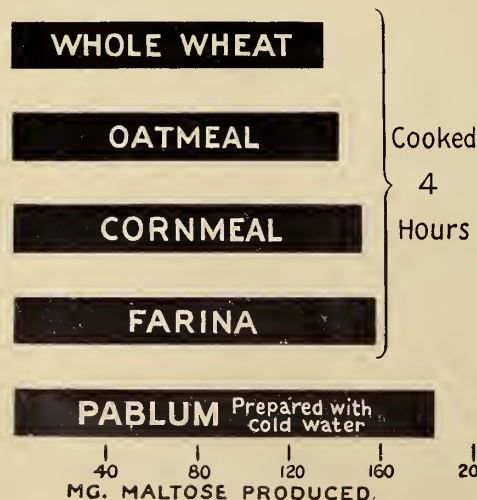
THE MALTBIE CHEMICAL CO., NEWARK, N. J.

Why Starch of PABLUM Is More Quickly Digested than that of Long-cooked Cereals

FOR many years it has been the custom to cook infants' cereal one, two, and even three hours to increase its digestibility. This bothersome and expensive long cooking is proven unnecessary with Pablum. For, being pre-cooked at 10 pounds steam pressure and dried, it is so well cooked that it can be served simply by adding water or milk of any temperature. Photomicrographs and also digestibility studies *in vitro* give evidence of this thorough cooking.

Fifteen cereals (both cooked and uncooked) studied microscopically were revealed as containing many starch granules, most of them massed into dense clumps. *Such unruptured clumps were never observed in hundreds of examinations of Pablum.* The latter consists, rather, of porous flakes which, like sponges, drink up liquids. Hence Pablum can be entirely saturated by the digestive secretions. This is borne out by studies of Ross and Burrill who found that the starch of Pablum is more rapidly digested than that of ordinary cereals cooked 4 hours.

Table shows that maltose production is much greater for Pablum prepared with cold water than for other cereals cooked 4 hours. Ross and Burrill (J. Pediat., May 1934) conclude from this and from the total soluble carbohydrate formed that starch digestion of Pablum is more rapid than that of 6 other cereals.



140 X. STAINED

(INSET) 290 X. STAINED

Large photomicrograph: Pablum mixed with cold water—portion of large flake. Pablum flakes are honeycombed with "pores" or air-spaces (note light areas). This porosity permits ready absorption of digestive fluids by the entire flake. No starch granules appear—they have been completely ruptured.

Inset: Farina cooked ½ hour—clump of tissue including starch granules. Note density of clump and lack of porosity. Many starch granules, such as are present in raw cereal, remain unchanged in form.

BESIDES being thoroughly cooked and readily digestible, Pablum supplies essential vitamins and minerals, especially vitamins A, B, E, and G, and calcium, phosphorus, iron, and copper. It is a palatable cereal consisting of wheatmeal, oatmeal, cornmeal, wheat embryo, alfalfa leaf, beef bone, brewers' yeast, and salt.

Reprint of Ross and Burrill paper sent on request of physicians.

MEAD JOHNSON & COMPANY
Evansville, Indiana, U.S.A.

THE OFFICIAL TRANSACTIONS

of the

168th Annual Meeting of the Medical Society of New Jersey

Held at Haddon Hall, Atlantic City, June 5, 6, and 7, 1934

Issued as a Supplement to The Journal of The Medical Society of New Jersey, August 1934

MINUTES OF THE HOUSE OF DELEGATES

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Tuesday Afternoon, June 5, 1934

The first session of the House of Delegates of the 168th Annual Meeting of The Medical Society of New Jersey convened in the Viking Room, Haddon Hall, Atlantic City, New Jersey, on Tuesday afternoon, June 5, 1934, at 2:15 o'clock, Dr. Frederic J. Quigley, of Union City, President of the Society, presiding.

1. OPENING

The invocation was given by Rev. Walter Bruggeman, of the Ventnor Community Church.

PRESIDENT QUIGLEY: The first of two ad-

resses of welcome will be given by Dr. David B. Allman, President of the Atlantic County Medical Society.

Dr. Allman welcomed the Society with best wishes for a successful meeting, and stated that he, together with many others of the medical profession in Atlantic County, was very anxious for the American Medical Association to hold its meeting in Atlantic City next year. He urged the New Jersey physicians who will attend the American Medical Association meeting in Cleveland next week to do all they can to endeavor to persuade the organization to come to Atlantic City next year.

PRESIDENT QUIGLEY: Thank you, Dr. Allman.

The second address of welcome will be extended by Mr. Louis St. John, President of the Atlantic City Chamber of Commerce.

Brief greeting and welcome by Mr. St. John.

PRESIDENT QUIGLEY: Thank you, Mr. St. John.

2. CREDENTIALS

See Section 34.

May we have the Report of the Credentials Committee?

DR. W. COLE DAVIS: Here on the blackboard you have the registration record for this noon, 1 o'clock, and 2 o'clock:

	Noon	1 p. m.	2 p. m.
Delegates	43	69	72
Members	24	36	42
Guests	62	99	118
Totals	129	204	232

3. PROGRAM AND ARRANGEMENTS

PRESIDENT QUIGLEY: I think we should like to have a word from Dr. Carrington, Chairman of the Committee on Program and Arrangements.

Announcement of program features by Dr. Carrington.

See Jour., May, pages 272 and 295.

DR. CARRINGTON: I move that the official program of this year be adopted as the order of business of this meeting.

The motion was regularly seconded, was put to a vote, and was carried.

See Sects. 40, 43 and 44.

4. REFERENCE COMMITTEES

See Sect. 27.

PRESIDENT QUIGLEY: I should like to suggest to the House of Delegates that the Chair be authorized to appoint additional Reference Committees, to which shall be referred the reports of officers and committees and new business. The Reference Committees will post on the bulletin boards the times and places of their meetings so that any members who have views to bring before them may do so. Full opportunity will be given the House of Delegates to amend or substitute any recommendations of the Reference Committees.

It was regularly moved and seconded that the President's request be granted as outlined above. The motion was put to a vote and was carried.

PRESIDENT QUIGLEY: I will, therefore, appoint the following Reference Committees:

Committee "A"—To consider the Report of the President, and addresses of President and President-Elect, Report of the Board of Trustees, Report of Publication Committee.

Dr. B. S. Pollak, Chairman
Dr. Thomas B. Lee
Dr. Daniel F. Featherston
Dr. David W. Scanlan
Dr. James J. McGuire

Committee "B"—To consider Reports of Finance Committee and Treasurer, Insurance Committee and Executive Secretary.

Dr. A. Haines Lippincott, Chairman
Dr. W. Edgar Darnall
Dr. William H. Areson
Dr. Samuel B. English
Dr. William D. Pedrick

Committee "C"—To consider reports of:
Committee on Honorary Members
Committee on Program and Arrangements
Committee on Scientific Work
Sub-Committee on Medical Education

Dr. Stephen T. Quinn, Chairman
Dr. Joseph Mark
Dr. R. M. A. Davis
Dr. George M. Levitas
Dr. E. G. Herbener

Committee "D"—To consider reports of the Sub-Committees of the Welfare Committee on Hospitals, on Medical Practice, on Workmen's Compensation, and on Medical Advisory Committee to the State E. R. A.

Dr. George T. Tracy, Chairman
Dr. Edward W. Sprague
Dr. William F. Costello
Dr. E. J. Chapman
Dr. Leslie E. Myatt

Committee "E"—To consider reports of:
Sub-Committee on Legislation
Sub-Committee on Uniform Medical Practice Act
State Board of Medical Examiners
Delegates to the A. M. A.

Dr. E. Zeh Hawkes, Chairman
Dr. Watson B. Morris
Dr. William J. Sweeney
Dr. Anderson A. Lawton
Dr. Robert W. Watkins

Committee "F"—To consider reports of:
Public Health Committee
Maternal Welfare Committee

Dr. Ralph K. Hollinshed, Chairman
 Dr. Dan S. Renner
 Dr. B. T. D. Schwarz
 Dr. Frederick H. Morrison
 Dr. George F. Dandois

5. MINUTES OF 167TH ANNUAL MEETING

PRESIDENT QUIGLEY: Next is the Reading of the Minutes.

It was regularly moved and seconded that the official minutes of the 167th Annual Meeting be adopted as printed.

DR. H. W. NAHEY: Mr. President, in connection with this motion I have the following report to make:

"The Board of Trustees has investigated and reported on a protest made by the Essex County Medical Society, which states:

"The Council of the Essex County Medical Society resents the introduction by the Secretary of the State Society in the Official Transactions of interpolated remarks or statements not made on the floor of the House of Delegates at the State Society meeting held in Atlantic City on June 6th, 1933, and demands a proper investigation and suitable action by the Board of Trustees of the Medical Society of New Jersey. The following members of the Council were present: Drs. Areson, Barkhorn, Bingham, Condon, Connolly, Eagleton, Hawkes, E. J. Ill, E. A. Ill, Kraker, Lowrey, Moore, Pinneo, Ranson, Rogers, Sprague, Stahl and Van Ness."

The protest, dated September 28th, 1933, relates to the insertion of a footnote by Dr. J. Bennett Morrison, Secretary, on page 40 of the Official Transactions of the 167th Annual Meeting of the Medical Society of New Jersey held at Atlantic City, June 6, 7, 8 and 9, 1933, which reads as follows:

"Dr. Reik, not having been present in the House of Delegates during the discussion given below, on the Report of the Committee on Finance and Budget, has filed a protest against some of the statements made by his opponents with reference to his salary and work, and has presented facts and figures tending to prove the inaccuracy and misleading character of those statements.—J. B. Morrison, Secretary."

"The Trustees have given due consideration to the explanation of the circumstances attending the publication of this footnote. However, the statement that 'a protest was filed against some of the statements made', is inaccurate; *no protest was filed with the Society or any officer of the Society by Dr. Reik*; and the Board of Trustees recommends that a resolution be introduced in the House of Delegates

stating that this footnote is inaccurate and that it be expunged from the Official Transactions of the 167th Annual Meeting of the Medical Society of New Jersey, held June, 1933.

"H. W. NAHEY, *Secretary*,
 "Board of Trustees."

The above report was offered as an amendment to the minutes and it was moved that it be treated as such. The motion was regularly seconded, was put to a vote and was carried.

The motion to adopt the official minutes of the 167th Annual Meeting, as amended, was put to a vote and was carried.

6. REPORTS OF OFFICERS AND COMMITTEES

PRESIDENT QUIGLEY: Inasmuch as the Reports of Officers and Committees have been printed in the Journal of May, 1934, they will be offered as printed, and referred to their respective Reference Committees; and as the committees are called upon, only supplementary reports will be read.

7. REPORT OF THE PRESIDENT

Original report, Jour., May, p. 255. Action by Reference Committee, Sect. 37, 38, 48.

PRESIDENT QUIGLEY: The President has no supplementary report to make, but the Executive Secretary has a supplementary report which I will ask him to read.

8. REPORT OF THE EXECUTIVE SECRETARY

Original report in May Jour., p. 256.

Dr. Wilkes read his supplementary report, as follows:

SUPPLEMENTARY REPORT OF THE EXECUTIVE SECRETARY

June 4, 1934

To the President of the State Medical Society:

The various activities outlined in the annual report of the Executive Secretary, and conducted in accordance with the plan presented by the President of the Society in October, 1923, might be better understood by the members if the general problems were briefly outlined to serve as a background. Into this background these activities fit as integral pieces of a composite picture. Among the urgent problems faced at the beginning of the present administration were the following:

1. The economic problem of the physician, which was due only in part of the general depression. Other factors were at work and some of these have been attacked with some success, especially through the projects of the Emergency Relief Administration and the Public Health Hour.

2. A lack of esprit de corps ("team work") was evident, not in the professional *practice* of medicine,

but rather in the *organization* for providing medical services in the community. This condition has been materially improved.

3. Definite plans for united action were needed with specifically allotted functions to be carried on in accordance with these plans. The ability and will of the membership of the Medical Society of New Jersey to furnish medical leadership and widespread participation in health programs and projects fitted to the local needs of each county, has been demonstrated and has attracted favorable notice and comment.

4. An aggressive legislative program was needed to put the cultists on the defensive, and to knit together more closely the members of the Medical Society. Both of these aims have been accomplished. Other groups who have been working in an organized way for their own interests, unmindful of the inherent rights and strength of organized medicine have had their respect for the profession renewed as a result of the Society's legislative success.

5. The ability of the profession to provide the most effective types of health protection and restoration has never been seriously questioned; but the manner in which these services have been made available to the public in the past, may in the future have to be improved in order to better meet the conditions of today and tomorrow. Such changes need not be revolutionary as some suggest, nor is any group or organization quite so fit for this job as the medical profession itself. There is often a distinct difference between a *new* way and a *better* way. The latter the Medical Profession in New Jersey is endeavoring to provide, but such improvement requires time and experience, as well as thought, and the final results can only be fairly judged by sound criteria, and not emotionally.

The public welcomes sound medical leadership when backed by widespread organized medical participation in meeting the urgent health needs of the individual and the community. That which is proven to be *better*, endures. That which is merely *new* soon becomes obsolete. A fine beginning has been made under the present leadership of the State and County Medical Societies, and that of the men chosen to serve on the committees.

5. The removal of the Executive Offices to the Capital City and the improved equipment have been justified by experience. Increased service and better legislative contact and supervision have resulted.

6. The organization under which the personnel of the Executive Staff are made directly responsible to the President of the Society has proved logical and effective. The work of the Executive Secretary during the past eight months has been agreeable, and he has received from the President, the officers of the State and County societies, and from the committee members with whom he has worked, the most cordial coöperation and support which he is glad to acknowledge at this time.

7. The further development of the plans so well laid during the year, demands continued unity, co-

operation, and persistent effort to protect and promote the welfare of the organized Medical Profession in New Jersey.

LeRoy A. Wilkes, M.D.,
Executive Secretary.

PRESIDENT QUIGLEY: This report will be referred to Reference Committee B, Dr. A. Haines Lippincott, Chairman.

Action, Sect. 39.

9. REPORT OF THE SECRETARY

Original report, Journal, May, 1934, page 261.

DR. QUIGLEY: The Supplementary Report of the Secretary, Dr. Morrison.

Dr. Morrison read his supplementary report, as follows:

SUPPLEMENTARY REPORT OF THE SECRETARY

Since my last report, we have added 135 names to the roster of paid-up membership for 1934, bringing the total up to 2886. At this rate we will reach the 3000 mark by the end of the year.

J. B. Morrison,
Secretary.

PRESIDENT QUIGLEY: This report will likewise be referred to Reference Committee A.

10. REPORT OF THE BOARD OF TRUSTEES

Original Report, Journal, May, 1934, p. 263.

PRESIDENT QUIGLEY: The Supplementary Report of the Board of Trustees, Dr. Wells P. Eagleton, Chairman.

DR. WELLS P. EAGLETON: Mr. President, according to the Constitution of the Medical Society of the State of New Jersey, "The Board of Trustees shall be the executive body of the Society, while the House of Delegates shall be the legislative body."

The Board, according to Chapter VI, "shall exercise general supervision over the affairs of the Society, with authority to act for the Society between annual meetings and to perform the following functions," and the functions are given.

At a meeting of the Board of Trustees in April, 1932, a plan was unanimously adopted to make the Society, with all its activities, revolve around the President during the year of his Presidency. I want to read that resolution, because it is far-reaching, and has had the happiest of results.

The plan is, first, to make the Society with all its activities revolve around the President during the year of his Presidency; second, to familiarize the incoming President with certain branches of

the organization; and, third, to have the Board of Trustees at each meeting in constant touch with the activities of the Society; as well as (fourth) to have the Chairmen of the important committees know what the Trustees are doing.

1. To have the Executive Secretary's office and all the activities under it, supervised by the President of the Society, who shall make a report of the activities of the Society at each meeting of the Board.

2. To have the Women's Auxiliary under the supervision of the President, who shall deal directly with the President of the Women's Auxiliary.

3. To have the Chairman of the Finance Committee present at every meeting of the Board of Trustees at which the finance matters are to be discussed.

4. To have the Chairman of the Publication Committee present at all meetings of the Board of Trustees.

5. To have the Committee on Program and Arrangements submit a report at the third and fourth meetings to the Chairman of the Board of Trustees. The third will inform the Board of what the Program and Arrangements Committee decide to do, and the fourth to show what has been done.

6. To have the President-Elect and the First and Second Vice-Presidents the Committee on Liaison between the Board of Trustees, and one to report to the Board of Trustees the activities of the Welfare Committee.

7. To have the Committee on Medical Education and Hospital Activities Chairman make a report which is to be submitted at the second and fourth meetings to the Chairman of the Board of Trustees; the second to advise what it is planned to do for the year, and the fourth to show what has been accomplished.

8. To have the special committees report directly to the President, who himself shall report the activities to the Board of Trustees.

That was adopted in 1932 and has had the most happy results. Every chairman of every important committee is present at the different meetings of the Board of Trustees, and the result has been that there is a coöperation that is impossible under any other form of organization.

Now the Board of Trustees has gone a step further and it is the unanimous opinion of the members that, as the President is going to devote his whole time (and he has but one year of office), it is the duty of everybody, every officer, every trustee, to get behind him thoroughly in all his activities.

At the first meeting at which I was elected Chairman, one of the first acts was to declare that this is a democratic organization and that a man should not continue too long in any one position. The President has his one year, and the Chairman of the Board of Trustees serves not more than two years, two terms,

and it was my privilege at that time, as I was a member of another committee, the Finance and Budget Committee (one of the most important committees), and as I had been elected Chairman of the Board of Trustees, to withdraw from the Finance and Budget Committee so that another member could be elected.

It is one of the greatest pleasures to all the Board to see the large number of committees and the large number of men who are now operating under different committees. If you will look at the back of your program you will notice that. This began last year, but it can be carried more and more this year. I think there are about 8 per cent of the total membership today serving on one or another of the committees. Is that not so, Mr. President?

PRESIDENT QUIGLEY: State and County?

DR. EAGLETON: Yes.

I shall not read the report. The most important thing was the divorcing of the editorship from that of the Active Secretary, the combined salaries of which positions were not to be more than \$12,500. A change was suggested in order to provide a full-time Executive Secretary, as due to the changed economic conditions it was thought necessary that physicians take a more active part in economic, political, and public health affairs. That has spread all over the State to all the separate counties.

The Board appointed Dr. Wilkes as Executive Secretary, at a salary of \$6,000 a year with a travel allowance not to exceed \$1,200 a year, and six cents per mile when using his car. The Board appointed Dr. Shipley as Editor and no sooner had he gotten well going when his value was recognized by Dr. Goldwater of New York, who is the Commissioner of Hospitals, who asked him to be his deputy, and as Dr. Shipley felt the opportunities of service were much greater there than in New Jersey, he asked to be relieved and his resignation was accepted with regret.

The Board then appointed the present Editor, Dr. Frank Overton, who has been the Editor of the New York State Journal of Medicine for ten years.

Mrs. Tancyhill and Miss Margaret Mahoney, who had been with us last year, both are married and had other plans and they could not continue with the Society.

One of the actions of the Board of Trustees was the establishment of the central offices of record and administration by a special committee consisting of Drs. North, Newcomb, Ely, and Herrman, at a rental of \$75 a month. It is located in Trenton.

While the work of the average county medical society is conducted by its members serving voluntarily, the activities of the Medical Society of New Jersey require the full-time services of a paid staff and the facilities of a well-equipped office, in order that the officers and committeemen may have the ready means for carrying out the policies and plans of the State Society; and may maintain intimate contact with the county societies and their members, and be ready to give them prompt assistance and advice.

The Medical Society of New Jersey is now entering its first year of the centralization of the administrative, journal, and clerical work in its own executive offices, which are located at 137 East State Street, in Trenton. It is a great pleasure to me to go and attend the meetings of the Board of Trustees in well-quartered offices in the heart of the State, in the capital of the State, where any member can go and get any information that is available.

The executive offices with their centralization of personnel and records, symbolize the unity of the members of the Medical Society of New Jersey, its aims and actions looking for a broader service for the doctors of New Jersey; and affords efficient integration and safeguard of the interests and activities of the society.

I think the past year under the wonderful leadership of the President, can be regarded as one of the epoch-making years of the Medical Society of New Jersey.

PRESIDENT QUIGLEY: The report of the Board of Trustees will be referred to Reference Committee A, Dr. Pollak, Chairman.

Action, Sect. 37.

11. COMMITTEE ON FINANCE AND BUDGET

Original report in Journal, May, 1934, page 272.

DR. HARRY R. NORTH: The Finance Committee met some time in April and, realizing that things aren't as good as they might be, we endeavored to make the budget as small as it is possible for good work. The following is the budget as adopted by the Committee:

Dr. North read the Provisional Budget 1934-35, as follows:

PROVISIONAL BUDGET 1934-1935

Publication	\$12,500.00
Welfare	750.00

Executive Secretary:

Salary	\$6,000.00
Secretary	1,300.00
Stenographer-typist	1,000.00

Rent	480.00
Office	1,550.00
Travel	1,200.00
	<hr/>
	11,530.00

Journal Editor:

Salary	\$5,000.00
Secretary	1,300.00
Travel and Convention	250.00
Rent	480.00
Office	500.00
	<hr/>
	7,530.00

President's Contingent Fund	2,000.00
Credentials Committee	300.00
Printing	1,800.00
Treasurer	75.00
Secretary:	
Salary	\$1,500.00
Office	1,000.00
Annual Meeting	700.00
	<hr/>
	3,200.00

A. M. A.	200.00
Arrangements	600.00
Secretaries' Conference	75.00
Scientific Exhibit	400.00
Guests	150.00
Public Health	500.00
Emergency Relief	200.00
Contingent Fund	1,500.00
Conference of Professional Societies	100.00
Cabinets	\$300.00
Mimeograph	250.00
Addressograph	200.00
	<hr/>
	750.00
Arts and Hobby Exhibit	50.00
Woman's Auxiliary	200.00
	<hr/>
	\$44,410.00

DR. NORTH: If that is divided among the number of members of the Society, you will find it comes to around \$16. Fortunately, last year we had a reserve and by squeezing pretty tight, we can keep the dues the same as last year, \$13, but I think we will be getting through just about by the skin of our teeth.

PRESIDENT QUIGLEY: This report is referred to Reference Committee B.

Action Sect. 39.

PRESIDENT QUIGLEY: Dr. Elias J. Marsh, the Treasurer, is unable to be here today, and so Dr. North will read the Treasurer's report, and then, while these reports will be referred to the Reference Committees for final action on Thursday, it might be well at this time, after he has read this report, if any members of the House have any questions with respect to either one of these reports, to ask them at this time, before the reports are referred. Will you present the Report of the Treasurer?

12. FINAL REPORT OF TREASURER

Preliminary report in Journal May, 1934, p. 262.

DR. NORTH: This report is lengthy to read and inasmuch as you all have copies in your hands, I don't believe it should be necessary to read it. If there are questions I can answer, I shall be glad to do it.

The report was as follows:

ANNUAL REPORT OF THE TREASURER

To the House of Delegates:—

A preliminary financial statement was published in the May JOURNAL, page 262, somewhat abbreviated in form. The complete report for the fiscal year has now been printed and distributed through the House, and a fuller report on financial matters has been presented to the Trustees, which will doubtless be available to enquirers.

In the statement presented herewith, an effort has been made to show whence the money comes and where it goes. Why it goes as it does; why so much or so little for this or for that, it is not the function of the Treasurer to say. You must ask the various operating officers and committees. The Treasurer is merely a sort of living cash-register. He takes in the money due the Society, and pays bills sent to him properly authorized and vouched, without asking why. It is his function to record and report the channels of distribution, and this the accompanying statement endeavors to make plain.

We all know that this has been another difficult year, and with the increase in the assessment some delay in payment was to be expected. However, most county treasurers were commendably prompt in their payments, and nearly all are now up to date, with the result that we have nearly thirty more members paid for than at this time last year. The banner goes to Burlington and Dr. Tracy, its Treasurer, who turned up 100 per cent a week before anyone else was heard from at all. Let us hope that next year things may be easier, and the record even better.

Respectfully submitted,

E. J. MARSH, Treasurer.

ANNUAL REPORT OF THE TREASURER

1934

PERMANENT FUND

DR.

June 1, 1933—

2 M 1st Liberty Loan 3½% bonds..	\$2000.00
4 M 4th Liberty Loan 4¼% bonds	4000.00
Mortgage Certificates, Investors Title & Mortgage Guarantee Company..	3000.00
Mortgage Certificate, Trenton Mortgage & Title Guarantee Company..	3000.00
Certificate of Deposit, First National Bank of Paterson, 3½%	3000.00

Jan. 31, 1934—

Profit on sale of 2 M 4th L. L. bonds, called	15.00
	<hr/>
	\$15,015.00

CR.

May 31, 1934—

2 M 1st Liberty Loan 3½% bonds	\$2000.00
2 M 4th Liberty Loan 4¼% bonds...	2000.00
2 M 4¼-3¼% U. S. Treasury bonds of 1943-5	1997.50
Mortgage Certificates, Investors Title & Mortgage Guarantee Company...	3000.00
Mortgage Certificate, Trenton Mortgage & Title Guarantee Company..	3000.00
Certificate of Deposit, First National Bank of Paterson, 3½%	3000.00
Deposit in Savings Account	17.50
	<hr/>
	\$15,015.00

GENERAL ACCOUNT

RECEIPTS

Balance, June 1, 1933

\$24,636.04

Assessment—

Atlantic	\$ 1,590
Bergen	2,745
Burlington	689
Camden	2,059
Cape May	290
Cumberland	663
Essex	10,169
Gloucester	544
Hudson	5,282
Hunterdon	296
Mercer	2,197
Middlesex	1,466
Monmouth	1,268
Morris	1,005
Ocean	247
Passaic	3,522
Salem	208
Somerset	637
Sussex	117
Union	3,233
Warren	345
	<hr/>
	38,572.00

Journal receipts	6,886.19
Interest	596.37
Associate subscriptions	354.75
Refund of salary overpayment	50.00
	<hr/>

\$71,095.35

PAYMENTS

For Publication Committee	\$11,917.34
" Welfare Committee	1,708.35
" Public Health Committee	80.12
" Emergency Relief Committee	62.85
" Other committees	65.80
" Board of Trustees	208.37
" General Offices:	
Clerical Services	\$2207.00
Operation and supplies	1486.09
Rent	866.67
Moving, furniture and equipment	1486.19
Travel account	1463.44
	<hr/>
	7,509.39
" Salaries:	
Secretary	\$1500.00
Executive Secretary	5666.67
Field Secretary	1333.33
Editor (including \$50 over-paid)	4633.33
	<hr/>
	13,133.33

For Expenses, President's office	143.54
" " Secretary's office and travel	1,874.26
" " Treasurer's office	63.25
" Printing, postage and stationery.....	1,697.04
" Annual Meeting, 1933:	
Program and arrangements. \$	995.51
Scientific Exhibit	289.74
Credentialed Committee	285.92
Guests	135.60
	<hr/>
	1,706.77
" County Secretaries' Conference	94.30
" A. M. A. Delegates' R. R. fares	223.29
" Conference of Professional Societies..	200.00
" Honorarium	100.00
" Viewing boxes	135.00
" Miscellaneous	27.31
Balance, May 31, 1934	30,145.04
	<hr/>
	\$71,095.35

BUDGET RECONCILIATION

Expected income	\$43,700.00
Actual receipts	46,459.31
Budget appropriations	42,867.00
Expenditures	40,950.31
Operating net balance	5,519.00

Respectfully submitted,

E. J. MAKSH, Treasurer.

PRESIDENT QUIGLEY: Are there any questions on the Report of the Committee on Finance and the Report of the Treasurer before they are referred to the Reference Committee?

If there are no questions, these two reports will be referred to Reference Committee B, Dr. Lippincott, Chairman.

Action, Sect. 39.

13. JUDICIAL COUNCIL AND MEDICAL DEFENSE

Original reports May Journal, pages 265 & 273.

Next will be the Report of the Judicial Council.

Action, Sect. 47.

We will change that a moment and make it the *Report on Medical Defense*. Dr. Beling and the other members not being here, the Secretary will read it.

Secretary Morrison read the Report of the Committee on Medical Defense, as follows:

SUPPLEMENTAL REPORT OF THE COMMITTEE ON MEDICAL DEFENSE 1934

To the House of Delegates:

Last year 1924 members were insured. This year 1996 members availed themselves of the special contract of the State Medical Society. One hundred and sixty-seven allowed their insurance to lapse by reason of failure to pay dues. In some

cases perhaps economic conditions were responsible but in many instances it was apparently through oversight or neglect.

The Committee again draws attention to the importance of prompt payment of dues, which is to prevent lapsing of insurance.

Morris and Hudson County Societies have 83.3 per cent of members insured. Last year Mercer County led with 83.1 per cent. The table gives the percentage by counties. We hope that every County Society will co-operate with the Committee next year to increase the numbers. We are aiming for 100 per cent so as to bring down the rates.

County	Membership	Insured	Percentage
Atlantic	107	69	.644
Bergen	160	125	.781
Burlington	53	28	.528
Cape May	20	15	.75
Camden	150	88	.586
Cumberland	51	36	.705
Essex	735	580	.79
Gloucester	36	21	.583
Hudson	391	326	.833
Hunterdon	20	10	.50
Mercer	169	129	.763
Middlesex	112	77	.687
Monmouth	91	55	.604
Morris	66	55	.833
Ocean	19	6	.315
Passaic	242	147	.607
Salem	16	10	.625
Somerset	49	22	.448
Sussex	19	8	.421
Union	229	176	.768
Warren	24	13	.541
	<hr/>	<hr/>	<hr/>
	2759	1996	.7234

The Committee has been assured that the present schedule of rates will not be increased. If the experience warrants it, the Committee will endeavor to obtain a reduction of rates and the restoration of the three-year plan, which carries with it a discount of 10 per cent on the installment basis and an extra 5 per cent on a fully paid-up three year contract.

Among the causes alleged in the claims made last year are: Postoperative drain in abdomen, Thrombosis necessitating amputation of leg, Alpine Lamp burn, injection for arthritis, alleged injuries to limbs and body by careless treatment, conspiracy in commitment to hospital for insane, Ultra violet ray burn of baby's leg, alleged injury to left breast resulting in cancer, operation for goitre with subsequent operation for gall-bladder resulting in death, pregnancy mistaken for tumor, careless delivery of child, careless setting of fractured wrist.

During the past few months there has been a startling increase in the number of claims made against doctors alleging malpractice or negligence. Almost without exception, on careful analysis it has been found there is absolutely no grounds for any claim for malpractice, negligence, error or mistake against the attending physician, and had

certain elementary rules been observed by the doctors, many of these claims would have been avoided.

This Committee is considering the advisability of the publication of a series of educational articles in the State Journal, the purpose of these articles being to point out the pitfalls and dangers involved in the present day practice of medicine and surgery. It is proposed to begin with the July issue and publish a series of twelve articles which will be prepared by the Committee, in conjunction with the insurance carrier, dealing with the keeping of proper records, the necessity for coöperation between doctors and hospitals and other points which may arise in the matter of malpractice claims.

The Committee desires to thank Mr. William N. Heard, our broker, for his continued coöperation and indefatigable efforts on behalf of the Society.

The Committee recommends the renewal of the contract for the ensuing year through the same agency.

Respectfully submitted,
Christopher C. Beling,
Chairman.
Edgar A. Ill,
John F. McCoy,
Erwin Reissman,
Wm. J. Arlitz,
Committee.

PRESIDENT QUIGLEY: This report will be referred to Reference Committee B, Dr. Lip-pincott.

Action, Sect. 39.

Are there any supplementary reports from any of the Councilors?

Is there any additional report, Dr. Hagerty, from the delegation to the American Medical Association?

14. DELEGATION TO THE AMERICAN MEDICAL ASSOCIATION

Original report Journal May 1934, page 267.

DR. JOHN F. HAGERTY: I may have had the wrong idea about what was intended and wanted in a supplementary report. Some things the President has said about the appointment of reference committees makes me think what I have to say may be appropriate, after all.

Dr. Hagerty read his supplementary report, as follows:

SUPPLEMENTARY REPORT OF THE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Mr. President:

While it is true that the great majority of physicians in our country are Fellows of the American Medical Association, few, I venture to say, know much about its affairs or the way in which the work of the Association is carried on. President

Quigley's request for a supplementary committee report has provided an opportunity to tell something about the composition of the House of Delegates, its mode of procedure, the volume of business transacted, and the relationship that exists between the parent organization and the component societies.

In doing this we are but carrying out the wishes of the House of Delegates as expressed by the Speaker, Dr. F. C. Warnshuis, at the meeting in New Orleans, 1932. "It has been recommended on several occasions that the delegates complete the discharge of their responsibility and duties by rendering to their respective State organizations detailed and explanatory reports of the activities of the House. This is most essential and desirable. State organizations stand in need of, and are entitled to, such information. They need to know the detailed action of the House for guidance in the administration of State organization affairs. National unity is unattainable without such instructive and guiding knowledge. You will render a distinct contribution to this Association and to your own State if you, as a delegate, render specific explanatory reports on the business transactions of each session of this House. It is on the recommendation of your Officers, Councils and Committees that your Speaker stresses this recommendation."

This statement from the Speaker of the House refutes the statement, sometimes heard, that the American Medical Association is not concerned with the problems of the profession. Further evidence of its interest was furnished at the last session, in Milwaukee, when it was decided that presidents of constituent societies be made ex-officio members of the House of Delegates; and again, by the action of the Trustees in continuing to send the Journal to delinquent members on their promise to pay, and thus preserving their membership in the Association.

The House of Delegates is composed of delegates elected by the constituent associations; and by the sections of the Scientific Assembly; and delegates from the Medical Department of the Army, Navy and Public Health Service, appointed by the Surgeon-General of the respective departments.

The total voting membership shall not exceed 175. The Medical Department of the Army, Navy, Public Health Service and Scientific sections shall each be entitled to one delegate, the remainder being apportioned among the constituent associations, such apportionment being made every three years. Delegates must have been Fellows of the Association at least two years. We learn from this that the House of Delegates is a representative body. A record of attendance of the delegates is made at each session and this record is published in the proceedings of the House.

The legislative powers of the Association reside in the House of Delegates. The House of Delegates shall transact all business of the Association not otherwise specifically provided for in the Constitution and By-Laws, and shall elect the general officers. This is further evidence of the democracy

of the organization, in that it elects the officers which directs its destinies.

The Board of Trustees, composed of nine members, elected at stated intervals by the Delegates, shall have charge of the property and financial affairs of the Association. The term of the Trustees shall be five years, and no Trustee shall serve for more than two consecutive terms.

When it is recalled that all of the delegates are men of years of experience, many of whom have held positions of honor and trust in their State organizations (in our own State all four delegates have been presiding officers) and that the office of Trustee is so highly regarded that only delegates of many years and those having several years' experience on reference committees are chosen, we get some idea of the respectability and capability of the Board of Trustees. The position is a very onerous one and involves a great sacrifice of time and effort in guarding the manifold interests of the Association. Some idea of the labor involved will be obtained by detailing the more important activities of the organization:

The Board of Trustees has charge of the publication of the *Journal*.

THE JOURNAL

"*The Journal of the American Medical Association* serves many functions. It is the official publication, providing all the official announcements and records of proceedings of the Association. It is a scientific periodical, which keeps its readers abreast of progress in medicine through original contributions and editorials. It is critical in its estimates of books, economic policies and legislation. It is a medical newspaper. It is a service publication, providing abstracts of articles in other periodicals and supplying answers to questions prepared not only by Association bureaus and departments, but also by a consulting staff of authorities. Medicolegal decisions of important courts are regularly recorded. Foreign correspondents in the Far East, in South Africa, and in all the important centers of Europe and South America keep readers of *The Journal* informed concerning scientific and medicosocial changes and advancements in their countries. Special issues of *The Journal* cover regularly the conditions of hospitals, medical colleges, licensing boards and clinical and radiologic laboratories in this country. During 1931, *The Journal* provided more than 4,300 pages of reading matter. At an average of 1,000 words a page, this material is the equivalent of fourteen average books or half the size of the *Encyclopedia Britannica*."

It also publishes special Journals; Archives of Medicine; Archives of Surgery; Journal of Diseases of Children; of Otolaryngology and Ophthalmology, Hygiene, etc. Also the Quarterly Cumulative Index Medicus. It maintains a large Reference Library, and operates a package library service; maintains a chemical laboratory, and provides the funds and supervises the work of the Council of Pharmacy and Chemistry, which

enlists the services of a large number of outstanding pharmacists, chemists and therapeutists. It supports the Council on Physical Therapy; the Bureau of Investigation of Foods and Drinks; Bureau of Economics; Bureau of Health and Public Instruction; Bureau of Legal Medicine and Legislation, and Bureau of Exhibits. The scientific exhibit has come to be, perhaps, the most prominent feature of the Association's annual sessions.

The cost of maintaining all these activities is paid out of funds received from the publication of the *Journal* and the benefits are obtained by Fellows of the Association for the purchase price of the *Journal*.

Besides these activities, it makes a large number of grants to individuals and institutions investigating disease problems throughout the United States. It defends all suits brought against the American Medical Association, and publishes complete reports of all these activities, which are published in the *Journal* or in separately bound reports, which are sent to the members, and a monthly bulletin which contains matters of immediate economic interest to the profession.

The business of the House of Delegates is conducted by a Speaker elected by the House, who is a trained parliamentarian, and a Vice-Speaker. They are ably assisted in this work by the Secretary, Dr. Olin West, who has a remarkably comprehensive grasp of the affairs of the Association. All of the business of the Association is presented to the House of Delegates at its first session and, after discussion, referred to the proper reference committees appointed by the Speaker, for consideration. The committees' reports upon these matters are considered and voted upon at the second or third sessions of the House.

In the formation of these committees, numbering altogether 66 members, representation is given to each State in proportion to numbers and to length of service of the delegates. The last session is usually an executive session, held within closed doors, at which matters of general public interest are considered and election of officers for the ensuing year.

I have attempted, in the short time allotted to me, to give some idea of the multitudinous activities of the American Medical Association and of the splendid way in which these activities are carried on and the interests of the profession considered and conserved by their representatives in the House of Delegates. As one who has had the privilege of participation in these deliberations, I wish to pay tribute to the devotion and zeal and whole-hearted interest of the officers and committees for the effective way in which the great work is conducted.

I have not had time to secure approval of the above statement from the other delegates, but feel certain they will subscribe to what I have said.

PRESIDENT QUIGLEY: This will be referred to Reference Committee E, Dr. Hawkes, Chairman.

Action, Sect. 42.

Is there a supplementary report from the Committee on Scientific Work?

The next report we will ask for is the supplementary report of the Public Health Committee, Dr. Nichols.

Original report May Journal, page 286.

15. REPORT OF THE PUBLIC HEALTH COMMITTEE

DR. STANLEY H. NICHOLS: I should like to thank Dr. Quigley and Dr. Wilkes for their help in coöperating with our Committee this winter. The names of our Committee were, unfortunately, omitted from the program, and I should like to thank Dr. Teimer, of Newark; Dr. Levy, of Newark; Dr. Shapiro, of Jersey City; Dr. Hummel, of Camden; and Dr. Knight, of Gloucester; and Dr. Ireland, of Trenton, for the very faithful work they have done this winter along the line of public health.

I am presenting a supplementary report to the report that was put in the JOURNAL last month.

Dr. Nichols read the supplementary report, as follows:

SUPPLEMENTARY REPORT OF THE PUBLIC HEALTH COMMITTEE

This Committee expresses its sorrow at the loss of one of its original members, Dr. Frank C. Johnson of New Brunswick, who passed to his eternal reward on New Year's Day. An unfortunate accident cut him off at the height of his splendid usefulness to his community, this committee, and the State Society, and those of us who knew him best will miss him sorely, because his unflinching courage, cheerful spirit, and devotion to child health have been rarely matched by anyone in medicine. I am sure that the State Society joins this Committee in expressing to his widow and children its thanks for the splendid service he has rendered as a faithful and useful member of our medical profession.

I wish to begin by quoting a resolution passed one year ago by the House of Delegates of our State Society. Quote: "The time has come for the State and County Medical Societies to assume the leadership and responsibility for the general health of the citizens of New Jersey, and thereby to preserve the personal and private relationship between physician and patient, which is the most desirable one for the health needs of the patient."

I wish to further quote from addresses before various county medical societies and other health organizations in New Jersey during the winter. Quote: "The Medical profession of New Jersey is at the crossroads. Either we must add to the burden of individual curative practice all the problems of community health, or political, social, and welfare organizations will attempt to assume them."

I am happy to report, that, after a winter of

strenuous and time-consuming work on the part of members of this Committee, and many of the officers and committee members of the State and County Societies, we have *left* the crossroads and are making definite progress along that difficult road, which might well be labeled *the Physicians' Recovery Road*. We call it the Physicians' Recovery Program, because we are attempting to recover for the physician many fields of health service, which he was in grave danger of losing altogether. This is being done, by assuming as State and County Societies, the responsibility for *public health leadership*, as well as that of *private medical care*. We have a rough and rugged road to travel, and it will take several years, and the wholehearted and loyal support of *every member of the State Society* before this ideal can be accomplished.

The challenge of the present social order (or disorder, as it seems to some of us at the present time) is adequate medical care for all of the American people.

While the overconfident and Utopian hope of perfect health and adequate economic bliss for all people, is the unrealizable dream of those who assume to speak for the present social order, better medical care can be provided. It has always been the constant goal of our medical profession for centuries. We believe that the seven groups of workers, whose sole profession is that of health, can join forces, and do this job of providing better medical care with better results, than by any other method so far offered.

I wish to quote from the Child Health Recovery Conference held in Washington on October 6, 1933. Quote: "Some of us in the Medical Society of New Jersey are gradually organizing all of New Jersey's professional health workers for real teamwork in public health service, and are positive that while the *quarterback* of this health team may be the trained health administrator, the *fullback must be the organized medical profession*, educated to *take responsibility for public health problems*, such as the one facing this Child Health Conference.

"The physician, collectively speaking, is the *senior member* of this health team of health officials, dentists, nurses, hospital workers, pharmacists, and medical social workers, and is now preparing in New Jersey to join forces with health officials, and add to his past burden of providing *individual curative* medical service, the *public health problems* of his *County and State*, with the coöperation and assistance of the rest of the health team.

"Some of us are convinced that it is only by placing our organized medical profession in the very forefront of organized responsibility for public health measures, that permanent success will come, along the line of real medical participation and teamwork. We admit that the physicians of the past, as a group, were individualists. Our task of the present is to help our membership to become more *public-health-minded*, and the time is now ripe for further advances along this line. We have no illusions that this can be done *quickly*.

It may take several years to accomplish, but we believe it *can be done* gradually. The Medical Society of New Jersey is in a position to be among the leaders in the United States in this respect. Socialized medicine, health insurance, political medicine, welfare medicine, and various other brands of social soothing syrups confront health workers on every hand, as a panacea for all health ills, but we believe that the *seven* groups of *health professionals* already mentioned can get together, and deliver better medical care and health to all people, by evolution rather than revolution."

The need of *pressing forward by continuous action* along these lines on the part of our State and County Societies is great. Only a few weeks ago national unemployment insurance was proposed by the Federal administration—Senator Wagner has introduced a bill—followed almost immediately by the New York City administration. Governor Moore is appointing a committee to study it. The New Jersey Hospital Association has adopted hospital insurance and is putting it into effect. *Unemployment insurance*, in the history of the world, has always been followed by sickness insurance, and we must be ready to meet these issues as they become *working realities*. The time is not far away. Our State and County Societies must be *so keenly organized* for the *effective delivery of health services* on the part of our *membership*, with the help of the other health professions, and our plans *so effectively made*, that our *health service* will be better than any other health plans offered for the medical care of the people.

The definite objective, presented by this Committee, and adopted by the State Society in June, 1933, was to have the State and County Societies, through their Public Health Committees, undertake the Diphtheria Immunization of babies and children between the ages of six months and six years, as the first step in pre-school supervision by the family physician. The object of this work was not so much as to get Diphtheria Immunization done, important as that is, but to create the health machinery in the State and County Societies by which other measures of public health nature can be gradually assumed, and thus create a responsible public health leadership of the State and County Societies, and recover for our physician members their rightful heritage.

The chairman of the committee, by invitation of the United States Secretary of Labor, and by direction of the President of the State Medical Society, addressed the National Child Health Recovery Conference at Washington on October 6, 1933, as to the readiness of the New Jersey State Medical Society to assume responsibility for any piece of child health work that might be set up by that conference in conjunction with the other health agencies of New Jersey under its public health plan. No specific federal funds were forthcoming, however, but authority was given to the State Emergency Relief Administration to assist in combating malnutrition in children. Dr. Julius Levy, a member of our Public Health Committee,

secured an agreement from the New Jersey Emergency Relief Administration that, on certification of a physician, extra funds, cod liver oil, orange juice, milk, etc., would be provided for malnourished children on relief. This has had splendid results in the State. Furthermore, an allotment of 160 civil workers and 100 unemployed nurses by the Civil Works Administration to the State Department of Health, was used by Dr. Levy to make a house to house canvass in the State, along the lines of our pre-school public health plan, by finding out the status of pre-school children as to Diphtheria Immunization, regular visits to their family physician, vaccination, and other factors in child health. These facts will be of inestimable value in the prosecution of our public health plan. This Society owes a vote of thanks to Dr. Levy for his cooperative spirit in converting these projects to the State Society's needs. Dr. Levy will present the findings of this pre-school survey at the Woman's Auxiliary luncheon Wednesday noon.

Once our County Societies and our individual physicians have created *efficient central County Medical Society offices in each County*, with *trained executives* for the purpose of connecting the *necessary health needs* of each county with the *health services* offered by *each participating member physician*, many income producing activities can be added to the physicians' public health hour.

In the prosecution of our plans we have had the effective cooperation of the State Department of Health, and we wish to thank Commissioner J. Lynn Mahaffey, who is an advisory member of our Committee, for his earnest efforts on behalf of the health projects of this Committee. Mr. Wm. H. MacDonald, Chief of the Bureau of Health Administration, and the District Health Officers have been invaluable in their untiring efforts to get together the Health Departments of each county when requested to do so by the Public Health Committee of the County Medical Society. This kind of teamwork between our Public Health Committees of our County Medical Societies and cordially cooperative local health officers is bound to bring results in this kind of health project. It has never been done before in New Jersey, and is meeting with general approval of many of the health observers in this State. The degree of success obtained will depend entirely on the careful thinking out of the details by each County Public Health Committee, and thorough follow-up work by our member physicians who enlist in this health project.

We wish to emphasize three things:

1. This work has just begun and is just getting under way.

2. This Physicians' Public Health Recovery Program is on trial—the eyes of all of the Health Agencies of New Jersey, and many in the United States, are upon us—they wish us well—but they are skeptical of our ability to create an organization efficient enough to successfully carry on this kind of project—they are willing to help us—but

we must make good—and this coming twelve months will be the crucial period in our attempts to carry the public health responsibilities we have already assumed.

3. Success will depend almost entirely—not on our leadership and plans, but—on whether *each individual member physician* will make an *earnest effort to understand the plans*, and loyally do *his individual share* in carrying out the personal health service, planned by his State and County Public Health Committee.

It is the earnest wish of our Committee, that with the help of every members physician of our State Society, standing solidly back of the Public Health Committees in every component medical society, we can place the organized medical profession of New Jersey in the *very forefront* of the *health groups* in this country, who are striving to *improve* medical service to the American people, and thus *retain* for our *individual physicians* the *proud heritage* of the past, in which the physician was recognized as the *foremost (public) health benefactor* of the *human race*.

PRESIDENT QUIGLEY: This report of the Public Health Committee will be referred to Reference Committee F, Dr. Hollinshed, Chairman.

Action, Sect. 43.

16. MATERNAL WELFARE

Original report Journal May, 1934, page 292.

We have a short supplementary report from the Committee on Maternal Welfare, which Dr. Bingham sent to me. He is unable to be present. He will be here tomorrow. It is an interesting report and reflects the respect that this committee has met with in its recognition by the largest State Society in the United States.

Secretary Morrison read the supplementary report of the Committee on Maternal Welfare, as follows:

MATERNAL WELFARE SUPPLEMENTARY REPORT

Since making the maternal welfare report, the Chairman of the Committee was invited to a conference with the Public Health Committee of the New York State Medical Society. A copy of a section of the annual report of this committee is attached.

"It offers the suggestion that commissions on maternal welfare be organized in each County Medical Society and that these local commissions assume the active leadership of all organizations in their respective communities working for the improvement of the maternity care. It is the belief of your committee that this problem belongs

to the County Medical Society and should be directed by it. The definite activities of such a commission in improving maternity care will undoubtedly accomplish much more than any extensive surveys or studies. This plan has already been adopted by the Medical Society of New Jersey with excellent results. Such county maternal welfare commissions should be organized under the Committee on Public Health and Medical Education which will be prepared to advise these commissions in regard to their specific duties.

"It is recommended that the House of Delegates authorize the appointment of a maternity welfare commission in each County Society for the purpose as stated."—(*New York State Journal of Medicine*, April 15, 1934, p. 345.)"

Respectfully submitted,

A. W. Bingham, M. D.,
Chairman.

PRESIDENT QUIGLEY: This report will be referred to Reference Committee F, Dr. Hollinshed, Chairman.

Action, Sect. 43.

17. PUBLICATION COMMITTEE

Original report, Journal, May, 1934, page 269.

Is the Chairman of the Publication Committee present, Dr. Barkhorn?

Dr. Barkhorn read the supplementary report of the Publication Committee, as follows:

SUPPLEMENTARY REPORT OF THE PUBLICATION COMMITTEE

The Publication Committee reports a most successful year. Due to the tremendous energy of Dr. Quigley and the many helpful suggestions received from both Dr. Quigley and Dr. Eagleton, the Journal has improved in every way.

We have had regular meetings at least once monthly and often several times a month. We are \$2,582.66 below our budget of \$14,500 and we have turned over to the Treasurer \$145.11 more than we did last year. With our present Editor we are sure we can look forward to continued improvement.

While it has not been customary for the Publication Committee to supervise the printing of the Official Transactions and the Official List, we are prepared to assume responsibility and to see that they are issued under our direction in the future as called for by the By-Laws.

A detailed financial statement follows:

RECEIPTS	
Advertising	\$8,294.81
Coöperative rebate	172.54
Extra subscriptions	42.50
Journal copies	10.86
Bills receivable	1,069.97
	<hr/> \$9,590.68

EXPENDITURES

Commission paid Coöperative..	\$ 653.16
Commission paid local agents ..	467.40
Discounts	161.92
Chairman's salary	250.00
Chairman's expenses	60.00
Tax on checks .....	.48
Printing and mailing Journal...	11,109.19
Reprints	198.75
Index	145.00
Addressograph	23.90
Stationery for special advertising	91.50
Newspaper subscriptions for editorial office	39.00
	<hr/> \$13,200.30

COMPARATIVE STATEMENT

	1932-33	1933-34
Advertising	\$9,235.89	\$8,294.81
Extra subscriptions	54.60	42.50
Sale of Journal	20.43	10.86
Printing and mailing of Journal	12,675.79	11,109.19
Reprints	231.50	198.75
Commissions	1,205.64	1,120.56
Discounts	184.51	161.92

SUMMARY

Amount of advertising secured by Coöperative	\$2,997.33
Amount of advertising secured locally....	4,015.00
Discount and commission allowed Coöperative	783.88
Discount allowed local advertisers.....	31.20
Commission paid local agents	467.40
Total amount of advertising	7,012.33
Total cash receipts, all sources	7,354.07
Total amount paid Treasurer (inc. \$128.29, Aug. advance)	6,886.19

RECEIPTS AND NET EXPENSES FOR THE YEAR

Printing and mailing of Journal	\$11,109.19
Reprints	198.75
Index	145.00
Addressograph	23.90
Chairman's salary	250.00
Chairman's expenses	60.00
Stationery for special advertising project	91.50
Newspaper subscriptions for editorial office	39.00
	<hr/> \$11,917.34

Henry C. Barkhorn,
Chairman

Linn Emerson
Edward J. Ill

PRESIDENT QUIGLEY: This will be referred to Reference Committee A. Dr. Pollak, Chairman.

Action, Sect. 37, also Sect. 46.

18. REPORT OF EMERGENCY RELIEF

ADMINISTRATION COMMITTEE

Original report, Journal, May, 1934, page 288.

DR. QUIGLEY: Next we will call for a supplementary report of the Medical Advisory Committee of the State Emergency Relief Committee, Dr. Spencer T. Snedecor, Chairman.

DR. SPENCER T. SNEDECOR: Mr. President and Members of the House of Delegates: This committee almost wishes it didn't have to make a report at all. We wish it were not necessary to have an Emergency Relief Committee. If the doctors could carry on financially and the present emergency didn't exist, we wouldn't think very much of our work; however, accepting conditions as they are, we would continue and add some supplementary remarks to what has already been published in the official organ.

A number of problems come to us week by week. At nearly every meeting something new has developed. We do not hold a brief for the desirability of the plan under which we are practicing, but we feel we are supplying a real need, and that the foundations of the medical relief plan are proper; that the poor of this state are being allowed a free choice of personal physician, for which the state is paying a modest remuneration.

We do not think this plan is working evenly in all respects. We have heard a number of complaints from physicians and we have complaints from the other side, too. It has been a challenge, gentlemen, to us to organize this plan to take care of the indigent sick and protect the members of the society. At the same time we find it very necessary to check on the doctors. Each month the monetary return to the doctors has increased. In March the doctors of the state received over \$50,000, in April \$57,000. The distribution of the money by counties is quite fair at present. For verification of the details of the plan, you may look to the published report.

Tomorrow morning at 10 o'clock your State Committee hopes to meet with all the County Committees and talk over a number of the problems now coming before us.

One of the new things that came up recently is an opportunity for the physicians of the state really to make money by examining the people who are being put on work for relief. There will be from 30,000 to 60,000 men being put to work and here is an opportunity for the doctors of the state to make between \$15,000 and \$30,000 out of that type of work alone.

We should like very much to have any interested

DR. BARKHORN: This makes a total net cost of \$12,560, a material reduction over any previous year.

members of the House of Delegates or the Society come to us and talk over their individual problems. County committees have been organized to carry on in each county, committees upon whom a large share of the responsibility must rest. Then we have been forced to put a lot of extra work on the individual doctors, not that we seek it, but as we get into this type of work, the details, and technicalities become greater and greater. For this reason we see no future in this type of practice. We hope it may come to an end in a year or two, but while it lasts, it is a challenge to the profession to see that it receives proper recognition; and, if the County Committees can function actively, so much more monetary and satisfactory recognition will they receive.

Mr. Compton, the new Executive State Director, has expressed the wish that the Emergency Relief agreement with the State Medical Society be continued for the coming year. Our relations with the State Officers and Executive Council have been most cordial. We have found it necessary to have frequent meetings with them to solve the numerous problems.

South Jersey recently called to our attention that the Emergency Relief was giving authorizations for contagious disease cases, such as measles and mumps; but when it came to paying for them they refused and said such authorization should not have been issued, because contagious diseases are the responsibility of the boards of health. As far as we knew, they should have been issued, and we are now getting it straightened out. They will be issued hereafter to all contagious diseases cases except where the county hospital is taking care of them.

The exclusion of school physicians and other salary doctors is an unnecessary restriction, you think. The question of your making out reports on all the work to send to the County Committee seems unnecessary, and yet, if we don't keep control of that, the E. R. A. will step in and do it for us. It is only by coöperating and working with them, giving them our point of view and standing up for our rights that we receive as much satisfaction as we do. If we as doctors do not make out medical reports for the county committees each month with a diagnosis of the cases, the next step will be a demand from relief officials that we put the diagnosis on the bill. This we do not desire, but yet, we may be forced into it.

The difficulties of this problem, gentlemen, come partly from another angle. The public has allotted a certain amount of money to pay for the care of people on relief. Relief Council is empowered to spend that money. It feels that it must search into each case in detail to see that it is spent wisely. If you analyze this whole set-up, the Relief Council authorizes the expenditure of these moneys, the doctors render the service, and again the Relief Council pays for it. They hold the balance both ways, at both ends. If they do not authorize service, we get nothing even though we render it, and if they don't pay for it we get nothing. Unless we fight continually to get in our

share of the rulings and see that fairness is done, we will lose out. They will encroach further upon our rendering of medical service if we are not very careful.

Our recommendation is, gentlemen, that the agreement with the Emergency Relief Administration of the State be continued for the succeeding year.

PRESIDENT QUIGLEY: The Report of the Medical Advisory Committee of the State Emergency Relief Administration will be referred to Reference Committee D, Dr. George T. Tracy, Chairman.

Action, Sect. 41.

19. COMMITTEE ON HOSPITALS AND MEDICAL EDUCATION

Original report, Journal, May, 1934, page 275

DR. QUIGLEY: I will next ask for the Supplementary Report of the Committee on Hospitals and Medical Education, Dr. Satchwell, Chairman.

Dr. Satchwell read the report, as follows:

SUPPLEMENTAL REPORT OF THE COMMITTEE ON HOSPITALS AND MEDICAL EDUCATION

To the House of Delegates:

This will complete the report of this committee for the academic year ending June 16, 1934, and is again submitted in two parts. Details of work done in the year by the Committee on Education are shown in the charts attached hereto.

PART ONE—MEDICAL EDUCATION

POST-GRADUATE COURSES

This committee feels that the didactic portion of its program is now fairly well established and that the program should now be broadened to include as much clinical teaching as possible. This will be done by clinical demonstrations of the lectures, laboratory courses in microscopic and gross pathology and clinical pathology. A third portion, which will be developed intensively, will be "Post-Graduate Opportunities". At the suggestion of the Board of Trustees all available Post-Graduate Opportunities in this state will be listed and submitted to the members of this society through the medium of the Journal. We have learned that many members of this Society are unable to avail themselves of the post-graduate opportunities offered by universities on both sides of the state in their curriculum because they are unable to afford the time demanded by these stated courses. Many opportunities exist in these teaching centers which can be fitted to the time which can be spent by these men who desire to carry on post-graduate studies. These opportunities will be published from time to time

in the Journal. Several of them are listed in this report.

COLLATERAL ACTIVITIES

In addition to those activities mentioned in the preliminary report, the following will be executed during the next year:

Arrangements have been made with Dean Ernest Little for courses in Materia Medica to be given by the faculty of the New Jersey College of Pharmacy for the benefit of the doctors. Your committee will give courses in Pharmacology for the pharmacists. These courses will be free and will be given at whatever centers in the state that shall be deemed desirable. The committee believes that this contact with the pharmacists will be of decided economic and educational benefit to both professions.

POST-GRADUATE OPPORTUNITIES

As mentioned before, a survey will be made of the Post-Graduate Opportunities available in the hospitals of the state and with the members of the State Society who are in a position to offer educational advantages to their fellow physicians. These will be published from time to time.

In the preliminary report mention was made of a number of men who were placed in the clinics and teaching centers outside of the state.

Since that report, Dr. Arthur Wright, Director of the New York University, Surgical Division of Bellevue Hospital, New York, has agreed to allow this committee to nominate each year two candidates for the three-year surgical course given by him in the New York University Medical College and in the wards of Bellevue Hospital. One vacancy exists for next year's course to begin in October.

CHART A

POST-GRADUATE MEDICAL PROGRAM

11 Centers

16 Groups

Conducted by

THE MEDICAL SOCIETY OF NEW JERSEY

in coöperation with

RUTGERS UNIVERSITY EXTENSION DIVISION

1934-1935

Centers and Courses	\$15.00		Number of Paid Registrations			Total Individual Class Reg. istrations
	Special	\$10.00	\$5.00 Special	\$3.00 Special	\$3.00 Internes	
1. Atlantic City (Atlantic & Cape May Counties)						
1. Clinical Neurology		23			11	34
2. Bridgeton (Cumberland & Salem Counties)						
1. Medicine and Surgery		22			1	23*
3. Camden (Camden & Gloucester Counties)						
1. Medicine and Surgery			69**			69*
4. Hackensack (Bergen County)						
1. Medicine				41†		41
5. Jersey City (Hudson County)						
1. Pathology			100**			100*
6. Mt. Holly (Burlington County)						
1. Medicine and Surgery		18				18*
7. Newark (Essex County)						
1. Ophthalmology	}.....	55†	89			302†
2. Medicine						
3. Applied Physiology—Part I						
4. Surgery						
5. Applied Physiology—Part II						
8. Newton (Sussex County)						
1. Medicine		13				13*
9. New Brunswick and Perth Amboy (Middlesex County)						
1. Medicine and Surgery		26				26
10. Somerville (Somerset County)						
1. Medicine and Surgery		26				26
11. Trenton (Mercer County)						
1. Medicine		22				61*
2. Surgery		39				
	55	278	169	41	12	713

* Registrations incomplete.

** Committees arranged special fee in order to make course available to more doctors.

† Special gift from the Bergen County Tuberculosis and Health Association made this fee possible.

‡ Discrepancy in Newark figures caused by special arrangement that \$15.00 registrations were permitted to enroll without further charge in any courses.

A similar course available to the men of South Jersey is now under consideration by the faculty of one of the Philadelphia Universities.

Dr. Bela Schick, Director of Pediatrics at Mt. Sinai Hospital, New York, has had for several years a post-graduate group of six students on Tuesday and Friday afternoons at that hospital. Dr. Schick has agreed to enlarge that group to include one man recommended each year by this committee. This program includes rounds and ward conferences. The opportunity will be available in October of this year.

Your committee, through the affiliations of the New Jersey State Medical Society with the various universities, is in a position to help the members of the Society to arrange courses of clinical study which will fit their available time and take this opportunity to offer that service.

NURSING EDUCATION IN NEW JERSEY

By virtue of the authority vested in this committee by the Board of Trustees at their meeting on April 22, 1934, this committee has begun a survey of education of nurses in New Jersey. For the purpose of this report, education of nurses can be divided into three parts:

1. Under-graduate education.
2. Post-graduate or further education.
3. University, or higher education.

1. Under-graduate education. By virtue of the Act of 1912 to regulate the practice of nursing in this state, educational requirements consisted of one year high school and two years' training in a school of nursing. Since that time practically all the schools in the state (36) have raised the requirements to four years' high school and three years of training in a school of nursing. With

these requirements fulfilled, a nurse graduating from a school has been able to obtain the privilege of using the abbreviation "RN" after examination by the State Board of Examiners of Nurses. In an attempt to secure reciprocity with other states for these registered nurses and to standardize these present requirements, the New Jersey State Association of Nurses is preparing a bill to legalize this standardization. Out of forty-four states with laws of this character, the standardization of nursing education in New Jersey under the law of 1912 is next to the lowest.

The Chairman of your committee and the Chairman of the Sub-Committee on Hospitals, Dr. Charles Kelley, have conferred with representatives of all the nursing groups in this state and a committee of the New Jersey Hospital Association and others interested in the bill.

The bill is "an Act to regulate the practice of nursing in the State of New Jersey, to register nurses with the privilege of using the abbreviation "RN" and to punish persons violating the provisions thereof. (Revision of 1934 Assembly 339.)

We have authority to state that the completed bill will not be introduced until next winter. On account of that and since this committee will submit a copy of the Act to the Board of Trustees of your Society with citations of the items demanding special study, we feel that a detailed report of the Act is unwise at this time. However, we wish to report that the Act will contain a provision for an Advisory Council consisting of two physicians nominated by the Board of Trustees of the Medical Society of New Jersey; two hospital executives nominated by the Executive Committee of the New Jersey Hospital Association and two registered nurses nominated by each of three groups representing the nurses.

By our advice, these appointments will be made

11 Centers

POST-GRADUATE MEDICAL PROGRAM

16 Groups

1933-1934

Center	Course	Opening Date	Closing Date	Time
1. Newark	Ophthalmology	November 22	January 3	8:30 p. m.
2. Hackensack	Medicine	January 5	February 9	8:30 p. m.
3. Atlantic City	Clinical Neurology	February 28	April 4	8:30 p. m.
4. Newark	Medicine	March 2	April 6	8:30 p. m.
5. Newark	Applied Physiology, Part I	March 14	April 18	8:30 p. m.
6. New Brunswick and Perth Amboy	Medicine and Surgery	March 29	May 3	4:00 p. m.
7. Newark	Surgery	April 13	May 18	8:30 p. m.
8. Mt. Holly	Medicine and Surgery	April 19	May 31	4:00 p. m.
9. Trenton	Medicine	April 24	June 12	8:30 p. m.
10. Trenton	Surgery	April 26	May 31	8:30 p. m.
11. Camden	Medicine and Surgery	April 25	May 31	4:00 p. m.
12. Newark	Applied Physiology, Part II	April 25	May 30	8:30 p. m.
13. Bridgeton	Medicine and Surgery	April 26	May 31	4:00 p. m.
14. Jersey City	Pathology	April 27	June 1	4:00 p. m.
15. Somerville	Medicine and Surgery	April 30	June 4	8:30 p. m.
16. Newton	Medicine	May 8	June 19	8:30 p. m.

by the State Board of Nurses Examiners and not by the Governor.

We have requested that the group sponsoring this Act consider enlargement of the State Board of Nurses Examiners to include two physicians appointed from nominations made by the State Medical Society and that the Advisory Council remain the same except for the omission of two physicians.

We are authorized to state that this request will be considered but that no decision will be made until after a survey of the experiences of the other state boards which include physicians. About 32 per cent of the state boards of Nurses Examiners have medical members. *

2. Post-Graduate Education for Nurses. In line with the present thought that a school of nursing owes a duty to its graduates to furnish post-graduate education, this type of education will in all probability be inaugurated next fall. Some lectures on medical subjects given by this committee in co-operation with one of the various groups of nurses may be given.

3. University Education for Nurses. A five years' course consisting of two years' university study and three years' study in an approved school of nursing, under the auspices of a university, will in all probability be organized within the next few years. A survey of this type of higher education has been made by Rutgers University and a report of that survey in the form of a paper on "University Education for Nurses" will be read by Mrs. Lydia Walker, of the Extension Division of Rutgers University at the annual meeting of the Hospital Association at Atlantic City on June 8th. The Chairman of your committee will discuss the paper.

Since a certain part of any program of this type is medical in character this Society should take an active part in such a program. Further reports will be made from time to time.

FACULTY

1933-1934

Numbers of doctors who lectured this year, from:

New York	19
Newark	1
Philadelphia	20

—
Total number of lecturers... 40

Frank E. Adair, M.D., Visiting Surgeon, General Memorial Hospital, New York.

Frederick M. Allen, M.D., formerly Director of the Physiatric Institute, Morristown, N. J.

Jesse O. Arnold, M.D., Professor of Obstetrics, Temple University Medical School, Philadelphia.

W. Wayne Babcock, M.D., F.A.C.S., Professor of Surgery and Clinical Surgery, School of Medicine, Temple University, Philadelphia.

William Bates, M.D., Assistant Professor of Surgery, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

E. J. G. Beardsley, M.D., Clinical Professor of Medicine, Jefferson Medical College, Philadelphia.

H. L. Bockus, M.D., Professor of Gastroenterology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

W. Emory Burnett, M.D., F.A.C.S., Lecturer on Surgery, School of Medicine, Temple University, Philadelphia.

M. A. Burns, M.D., Professor of Nervous and Mental Diseases, Jefferson Medical College.

Abraham Cantarow, M.D., Assistant in Medicine, Jefferson Medical College, Philadelphia.

Clarence E. De La Chapelle, M.D., Assistant Professor of Medicine, New York University Medical College, New York.

C. Ward Crampton, M.D., no university title.

Roger H. Dennett, M.D., Professor of Pediatrics, Columbia University, New York Post-Graduate Medical School, New York.

John F. Erdmann, MD., Professor of Surgery, Columbia University, New York Post-Graduate Medical School, New York.

Temple Fay, M.D., F.A.C.S., Professor of Neurosurgery, School of Medicine, Temple University, Philadelphia.

Thomas Fitz-Hugh Jr., M.D., Assistant Professor of Clinical Medicine, University of Pennsylvania Medical School; Chief of Hematology Section, Medical Clinic, Hospital of University of Pennsylvania, Philadelphia.

J. Irving Fort, M.D., Chief of Fracture Service, St. Michael's Hospital and Presbyterian Hospital, Newark, N. J.

Robert T. Frank, M.D., Visiting Gynecologist, Mt. Sinai Hospital, New York.

Vaughn C. Gardner, M. D., Assistant Professor of Dermatology and Syphilology, University of Pennsylvania Medical School, Philadelphia.

John C. Gittings, M.D., Professor of Pediatrics, University of Pennsylvania Medical School, Philadelphia.

Harry Gold, M.D., Assistant Professor of Pharmacology, Cornell University Medical College; Chief of Cardiac Clinics, Beth Israel and Hospital for Joint Diseases, New York.

Benjamin Gruskin, M.D., Director of Oncological Research in the Department of Pathology, Temple University Medical School, Philadelphia.

Frederick C. Holden, M.D., F.A.C.S., Professor of Obstetrics and Gynecology, New York, University Medical College, New York.

Paul Klemperer, M.D., Pathologist of the Mt. Sinai Hospital, New York.

Edward J. Klopp, M.D., Professor of Surgery, Jefferson Medical College, Philadelphia.

John A. Kolmer, M.D., Professor of Medicine, School of Medicine, Temple University, Philadelphia.

Edward M. Livingston, M.D., Visiting Surgeon, Bellevue Hospital; Instructor in Surgery, New York University Medical School, New York.

John Royal Moore, M.D., Professor of Orthopedics, School of Medicine, Temple University, Philadelphia.

John J. Moorhead, M.D., F.A.C.S., Professor of Traumatic Surgery, Columbia University Post-Graduate Medical School, New York.

George Muller, M.D., Professor of Clinical Surgery, University of Pennsylvania Medical School, Philadelphia.

H. A. D. O'Connor, M.D., Assistant Visiting Surgeon, New York University Division, Bellevue Hospital, New York.

Marshall C. Pease, Jr., M.D., Professor of Pediatrics, Post-Graduate Medical School and Hospital, Columbia University, New York.

Bernard Samuels, M.D., Professor of Clinical Surgery, Department of Ophthalmology, Cornell University; Surgeon and Pathologist, New York Eye and Ear Infirmary, New York.

Bela Schick, M.D., Director of Pediatrics, Mt. Sinai Hospital, New York.

E. A. Spiegel, M.D., Professor of Applied and Experimental Neurology, Temple University School of Medicine, Philadelphia.

Samuel Standard, M.D., F.A.C.S., Instructor in Surgery and Assistant in Physiology, New York University Medical College, New York.

William D. Stroud, M.D., Professor of Cardiology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

Asher Winkelstein, M. D., Chief of Gastroenterology Clinic, Mt. Sinai Hospital, New York.

John Wyckoff, M.D., Dean of Medical School, Professor of Medicine, New York University Medical College, New York.

POST-GRADUATE MEDICAL PROGRAM

1933-1934

FINANCIAL REPORT

June 2, 1934

Cash Received	\$2,236.00
Cash Collectable	2,707.00
Total Income	\$4,943.00
Estimated Direct Field Expenses (Approximated as closely as possible at this date)	
96 Lectures, at \$25.00	\$2,400.00
Travel Expenses of Lecturers	664.00
Printing and Mimeographing	384.24
Expenses of University Technical Advisor	200.00
Travel Expenses of University Extension Staff	495.16
University Telephone and Postage	330.00
One-third time of Stenographer	360.00
Total Expense	4,833.40
Estimated Surplus	\$ 109.60

DR. HARRY H. SATCHWELL: Part 2 was to have been read by Dr. Kelly. He is not here,

but it did not change in any way the report of the Board of Trustees, and I suggest we be allowed to submit that to the Committee on Reference.

PRESIDENT QUIGLEY: If there is no objection the report of the Sub-Committee on Medical Education of the Committee on Hospitals and Medical Education be referred to Reference Committee C, Dr. Stephen T. Quinn, Chairman.

Action, Sect. 40.

The report of Sub-Committee on Hospitals will be submitted to the Reference Committee, D, Dr. Tracy, Chairman.

Action, Sect. 41.

PRESIDENT QUIGLEY: We will now proceed to supplementary reports of the Welfare Committee, and these will be submitted as supplementary reports of the Sub-Committees of the Welfare Committee. I will first ask for the report of the Sub-Committee on Medical Practice, Dr. Lewis.

Action, Sect. 40.

20. SUB-COMMITTEE ON MEDICAL PRACTICE

Original report in Journal May, 1934, page 280; and also July, 1934, page 383.

Dr. Lewis read the abstract of the report of the Sub-Committee on Medical Practice, as follows:

ABSTRACT OF ANNUAL REPORT BY THE SUB-COMMITTEE ON MEDICAL PRACTICE

By THOMAS K. LEWIS, M.D.

Pursuant to the request of Dr. Quigley, the Sub-Committee on Medical Practice during the past winter has confined its activities largely to a consideration of Dispensary Abuses and Contract Practice.

DISPENSARIES

A brief State-wide survey revealed the prevalence of certain abuses with which the delegates have been made familiar. A Dispensary Plan was devised and published in the May issue of the State JOURNAL. We recommend:

- 1—That a standard form of dispensary set-up and management shall be adopted by the New Jersey State Medical Society.
- 2—That such set-up should be forwarded to all hospitals of the State, urging its adoption.
- 3—That it shall be urged by this Society that the American Medical Association adopt a definite dispensary plan and that the Hospital Committee of the American Medical Association be empowered, eventually, to insist upon adherence to such plan by all hospitals falling under its jurisdiction.

CONTRACT PRACTICE

Our survey revealed examples of this form of practice at its worst and at its best with many gradations between. Irregularities were encountered

ered not only in industry, but in State and school medical services. A code for governing Ethical Contract Practice has been drawn up. The following recommendations are presented for the approval of this body:

- 1—The adoption of a code for standardization and regulation of Contract Practice.
- 2—The instruction of our members, particularly the younger men, in the ideals of ethical practice, and the encouragement of our members to consult with and accept the advice of the Boards of Censors of the respective component societies when contemplating the acceptance of any contract position.
- 3—The institution of a campaign for modification of School Medical Service, either toward limitation of present activities or for their more thorough execution.
- 4—That a concerted and sustained effort be made to remove State and municipal medical positions from political control and to procure for these positions adequate remuneration.

Among the activities of the Sub-section on Medical Practice was a meeting with a committee of the State Pharmacal Society—for consideration of a proposition offered by the latter group. In brief, it was the establishment of what might be called a New Jersey Formulary, the purpose of which is to standardize various preparations of new and non-official remedies of proven worth until such time as they or similar preparations have been added to the U. S. Pharmacopea. The druggists have developed a group of formulae, with designations suitable for prescription writing, which are palatable and stable—equal to or surpassing in elegance a host of preparations now appearing under a variety of trade names. The advantages to be gained by this step are as follows:

- 1—A dignified way of prescribing new and non-official remedies without the necessity of using trade names.
- 2—A saving in money to the patient.
- 3—Reduction in tendency to verbal prescriptions and counter dispensing.
- 4—Encouragement for the druggists to return to the proper use of their professional knowledge.
- 5—A means of encouraging and training the medical profession back to the use of official U. S. P. and N. F. remedies.
- 6—And, as an outgrowth of the latter, by reducing the cost of prescriptions, in those communities habituated to dispensing, render a return to more extensive prescription writing practicable.

The Sub-Committee on Medical Practice was heartily in accord with the proposed plan. It would recommend:

- 1—Cooperation with the druggists in this matter, and the official approval of this plan by the New Jersey State Medical Society.
- 2—Publishing of the formulae prepared to date in the State JOURNAL.
- 3—The production of reprints of this proposed N.

J. Formulary in book or pamphlet form for distribution to the physicians of the State.

- 4—The appointment of a permanent committee to cooperate with the committee of the Pharmacal Society in the selection of remedies to be included in the N. J. Formulary.

Another activity which warrants mention in this report is that of the proposed formation of a Conference of Allied Medical Professions—including nurses, pharmacists, dentists and physicians. Representatives from the four societies met and discussed the feasibility, scope and possibilities involved in such an alliance. Following this meeting a committee was designated, consisting of one member from each of the four groups, whose duty should be to crystalize the thoughts expressed at the first meeting and draw up in concrete form the scope of activities and scheme for organization of such confederation. Following, in brief, is the outline:

Name—Conference of Allied Medical Professions of the State of New Jersey.

Purpose—

- 1—For combined action in legislative matters which involve all four societies or which, while immediately effecting any one group, in principle might involve the preservation or enhancement of the high standards of every branch of the healing art.
- 2—for expansion and education in public health matters.
- 3—For cooperation in various phases of medical economies.

Administration—The conference shall be composed of representatives from each of the component State societies. There will be no voting power. Concerted action will arise only as a result of mutual consent of all groups. Sub-councils will be organized in each county upon a similar plan for the purpose of exerting a united front in local matters. In State and national matters the county groups will act in accordance with the policy determined upon by the State Council.

This proposed organization has received the approval of the Trustees of the New Jersey State Medical Society and now awaits final action by this body.

Thomas K. Lewis,
Chairman.

Action, Sect. 41.

21. WORKMEN'S COMPENSATION

Original report in Journal May, 1934, page 282.

PRESIDENT QUIGLEY: Dr. Kraker, chairman of the Sub-Committee on Workmen's Compensation, wrote telling me he was unable to be here, but would be here tomorrow. He said there would be nothing to add to the report which was published.

Action, Sect. 41.

22. SUB-COMMITTEE ON LEGISLATION

Original report in Journal May, 1934, page 278.

PRESIDENT QUIGLEY: Next I will ask for a supplementary report of the Sub-Committee on Legislation, Dr. D. Leo Haggerty.

Dr. Haggerty presented the report, as follows:

SUPPLEMENTARY REPORT OF THE COMMITTEE ON LEGISLATION

By DR. LEO HAGGERTY, Chairman

Inasmuch as my preliminary report carried the status of legislation until May 3rd when Legislature adjourned, my final report will be brief, as the only new matters was the action of the Senate on medical bills last night.

The bill for Toxoid for this year was passed too late to allow the appropriations committee to use this as a precedent and include it in the appropriations bill this year, so it was necessary to introduce a separate bill for funds for next year. This bill, known as Senate Bill No. 338, was introduced by Senator Cole last night and under suspension of rules was advanced to third reading and unanimously passed by the Senate, and we feel that we have the ground work laid so that it will pass the Assembly today. Assembly Bill No. 313, exempting the professional boards from the provisions of the Budget Act, was reported out of committee and will probably be voted upon in the Senate today. We feel that we have sufficient votes to pass this bill.

The Beauticians Bill, Assembly No. 22, which passed the Assembly the last day before the recess, out of courtesy to the Assemblywoman who introduced the bill, is now in the Senate. The Beauticians had a strong lobby last night in the Senate and when they found that the medical profession was strongly opposed to the measure in its present form, were agreeable to almost any amendment, and I think will be willing to make their bill simply a regulatory measure and operate under a code controlled by the State Board of Health.

Now let me briefly review the work of the Legislative Committee of this past year. This year we changed from a defensive committee to an offensive as well. This was made necessary by the number of bills we introduced and made it important that we have a well organized plan of procedure. We adhered to the policy of previous years that there should be no lobby in Trenton, but that contact should be made at home. Thus keymen were appointed in each county to keep their representatives informed on medical matters and to obtain their views.

When a bill was introduced they saw their Senator and Assemblymen and gave our reasons for supporting or opposing such bill. Then the Executive Secretary, when a bill was ready to be moved, had a roll call on how each county stood. How accurate this count was, is evidenced by the Assembly vote on the Physicians' Lien Bill.

We had a count of 37 for, the day of the vote and it passed by 39 to 14. Our response to requests

for information from the keymen has been very good up until the recess of Legislature and this accounts for our good results, but during the recess we asked for a roll call on present legislation, particularly measures to which we were opposed, and received but two replies. I do not know whether it was because we had passed most of our bills and should rest content, but during the closing hours of Legislature is the time we have to be on our guard for the passage of cult bills, so we earnestly ask that you persevere with us to the end.

Our most important offensive measures in the past year were as follows:

Senate Bill No. 136, adding a Physicians' Lien to the Hospital Lien Bill, was made a law. I consider this the most important measure as far as the medical profession is concerned, since the Workmen's Compensation Act. A-373, appropriating \$10,000 for toxoid to be used in the prevention of diphtheria during 1933-1934, and Senate Bill 336, appropriating \$22,000 for toxoid in 1934-1935, and Senate No. 251, allowing the school physicians to participate in ERA funds.

This in itself is a fine showing, but when we consider that we have successfully opposed the following cult bills:

A- 22 Beauticians' Bill, we will call it a full year.

S- 73 Osteopathic bill

S-207 A vicious cult bill

A-303 A combination cult bill

A- 22 Beauticians' bill,

In closing, I would like to thank all members of the Legislative Committee for their attendance at meetings and faithfulness, all keymen for their energy and promptness, our Executive Secretary for his loyal support and performance of duties well done, and President Quigley for his wonderful leadership, and the fact that he does not ask a man to do what he would not do himself, and to Dr. James J. McGuire for his many analysis of medical bills and his attendance and work at all legislative sessions. My one recommendation for the future would be that we have several men like Mac to analyze bills. Many an innocent looking bill has many hidden features that is only recognized by men knowing the logic of careful analysis. But I would appeal to the rank and file of the medical profession to be on the alert and not expect George to do it all, and if we are to be successful in future legislation we must have a united front. Let me just quote from an article in the May number of the *American Mercury* on the "Plight of the Doctor," written by George W. Aspinwall, a layman:

"Family doctors, alone and in small groups, tried to convince the legislators that the bill should be passed. The doctors were told bluntly that few physicians take part in primary contests, that only about a third of the physicians in the State register for voting, and that therefore they had no claim on the legislators and no power to procure enactment of the law. The bills were defeated but the family doctors who would have benefited by their enactment had their eyes opened. The result

of their mission to Albany is that the doctors are forming political organizations with the intention of making a fight. The family doctor never has been politically important. He has been too busy with his practice to find time for meddling in politics. But it seems that now, when he cannot earn enough money to support his family, he may meddle politically a bit.

The family doctors of not only New York State but throughout the country are sufficiently numerous with their families and friends to wield a powerful political influence if they should band together under proper leadership to battle with the ballot for self-preservation.

It is conceivable that the family doctors of New York State could push a bill similar to the Crawford one through their State Legislature. And it is not improbable that the family doctors of the nation could induce Congress to see that Uncle Sam takes the M.D. off his door. There are quite a few members of Congress who believe that World War veterans should be treated in hospitals in their own State by their home-town physicians, and that these physicians should be paid by the Federal government.

There certainly is merit in the contention of the doctors that they should be paid for treating the poor. The poor must have medical treatment and the treatment must be free, but the bill should be shared by the community."

D. Leo Haggerty.

PRESIDENT QUIGLEY: This supplementary report on legislation will be referred to Reference Committee E, Dr. Hawkes, Chairman.

Action, Sect. 42.

I sent out a little memo to the committee chairmen, but it might not have reached them all, and so I make the suggestion that the Reference Committees meet immediately after adjournment and organize, and contact Dr. Carrington, Chairman of the Program and Arrangement Committee, the Secretary of that Committee, Dr. Olmstead, or the Executive Secretary of the Society, Dr. Wilkes, to arrange for announcements on blackboards of the times and places of the meetings of these Reference Committees, which preferably should be held tomorrow morning, or, if necessary, Thursday morning.

Next is the report of the Sub-Committee on Uniform Medical Practice Act, Dr. Alexander.

23. SUB-COMMITTEE ON UNIFORM MEDICAL PRACTICE ACT

Original report, Journal May, 1934, page 286.

Dr. Samuel Alexander read his report, as follows:

SUPPLEMENTARY REPORT OF THE COMMITTEE ON THE UNIFORM MEDICAL PRACTICE ACT

By SAMUEL ALEXANDER, M.D.

Since the approval of the report of the Committee on the Uniform Medical Practice Act by the Welfare Committee, it will be necessary before introducing this Uniform Medical Practice Act in the Legislature, to obtain a definition covering the practice of chiropody in the present law, as there is no definition in the law at the present time. Otherwise, if the Uniform Medical Practice Act is obtained before this definition is included in the Chiropody Act, the chiropodists will be able to practice with little fear of prosecution.

It may be wise to have conferences with the various groups involved before introduction of this bill.

A careful check-up of the present Medical Practice Act and amendments thereto will have to be made so that this new legislation will not weaken the present act in any way, since the present law covers the regular physician very effectively.

Samuel Alexander, M. D.,
Chairman.

PRESIDENT QUIGLEY: This supplementary report will be referred to Committee E, Dr. Hawkes, Chairman.

Action, Sect. 42.

24. SUB-COMMITTEE ON PHYSICIANS' LIEN ACT

There is one committee that was appointed since the reports were formulated and printed in the JOURNAL, namely a Special Committee to the Welfare Committee, which was appointed as an outgrowth of the passage of Senate Bill No. 136, the Physicians' Lien Law. It appealed very strongly to the Welfare Committee and likewise to the Board of Trustees that the inauguration of this new plan should be very carefully approached, and the first purpose of this Committee was to draw up a suggested schedule of minimum and maximum charges to be used by the County Societies in formulating their schedules; and the second thing decided upon was that the schedules formulated by the County Societies were to be submitted to the State Committee for review and approval before being advertised in conformity with the Act.

The personnel of the Committee was carefully selected from various parts of the State, including urban and rural counties. The matter is of great importance and I will ask the Chairman of the Special Committee to the Welfare Committee, Dr. Weigel, to make a report at this time.

Dr. Weigel read the report, as follows:

REPORT ON PHYSICIANS' LIEN LAW

By ELMER PETER WEIGEL, Chairman

Your Committee appointed to study the Doctors' Lien Law (Senate Bill No. 136) has given much thought and time to its various provisions. We have prepared a suggested schedule of fees. We have also drawn a form to be used in filing our liens, and formulated letters transmitting the lien both to the Clerk of the Court and to the defendant.

We have been approached by representatives of the insurance carriers, assuring us of their desire to cooperate in the smooth functioning of the bill, but as yet we have not furnished them with a copy of the proposed fee schedule.

We have also been approached by representatives of several legal organizations with offers of handling these liens for us, but it is our thought for the present at least, that we had best file our liens individually.

In order to give the members some idea of the fees suggested without boring you with six long pages of figures, I might briefly state that we suggested—

- \$3.00 to \$5.00 for a house, office or hospital call.
- \$10.00 to \$100.00 for consultation, depending upon time consumed and distance traveled.
- \$200.00 to \$400.00 for treatment of a fractured femur.
- \$200.00 to \$300.00 for laparotomy for ruptured liver.
- \$200.00 to \$500.00 for fractured skull requiring operation, etc.

We feel, however, that before this schedule of fees is sent to the various County Societies for their adoption and presentation before the Judge of the Circuit Court, it should have some thought and discussion in the House of Delegates.

It was our first thought that these fees should be quite moderate so as not to arouse too much opposition to their adoption. We believed that they will be attacked by both the legal profession and the insurance carriers, and felt that by holding them quite reasonable there would be less cause for criticism. It might be argued that whatever we received from the average liability case would be more than we have been getting in the past.

I think many of us have come to consider these cases as being worth about as much as a similar compensation case. We feel, however, that these cases should be considered from a different viewpoint. They are potentially private patients. Compensation fees have been set by law and are administered by a referee, and we have no voice in establishing their amount. Fees for liability cases will be contingent upon the patient eventually getting a judgment against the defendant and he in turn being financially able to meet that judgment.

The various County Societies as representatives of organized medicine in each county are compelled by this law to state what the proper fee

shall be for each type of operation or treatment in that county. Are we prepared and willing to so commit ourselves?

We have prepared our list with a minimum and maximum charge for each treatment and yet if my judgment is correct the minimum fee will soon become the established fee.

I think we are all agreed that in private practice fees are based very largely upon the skill, experience and reputation of the physician or surgeon involved. I see no way in which any of these factors can be given consideration under a pre-arranged fee schedule such as we are asked to submit.

What will be the effect of such a fee schedule on our private practice? What will be our answer to the private patients who may be well able to pay more for his care when he asks why his bill is higher than the amount agreed upon by the County Society?

Is it not possible also that some of us may be compelled to sue for collection of a bill, not necessarily in a liability case and find that the amount is considered unreasonable if it is in excess of that mentioned in this fee schedule?

These are some of the points which your Committee would like to have discussed by members of the House of Delegates.

Respectfully submitted,
Elmer Peter Weigel, Chairman,
Plainfield, N. J.

PRESIDENT QUIGLEY: It has been clearly recognized that the passage of this bill, like many other good things, is not an unmixed blessing and, as Dr. Weigel has pointed out, there are serious problems which must be settled. I will refer this to Reference Committee E, Dr. Hawkes, Chairman. With respect to this report, as well as others, in advance of their consideration here on Thursday afternoon, if any members who have any particular views they feel might be helpful to the Reference Committee in formulating their report, of course they are at liberty to appear before that Committee and state those views.

Action, Sect. 42.

25. COMMITTEE ON INSURANCE

DR. FRANK W. PINNEO: Apparently this supplementary report is to be brief and not repeat what has already been published. This will cite certain outstanding features for your information.

Dr. Pinneo gave a brief abstract of the report which was printed in the May JOURNAL, page 273.

DR. PINNEO: It just occurred to us it might be interesting for you to read some of the reactions of our members in cases during the past year. You noticed we cited one case where a national automobile association for

six months had had a little claim of a member, not enough to bring to court, but when our agency was consulted, in three days the defendant paid the amount, and it was handed over to our member without any cost.

Here is a letter from Camden County to the Secretary, Dr. Gamon:

"As Secretary of the County Medical Society you might be interested, also the members, to know that I carry insurance with National Casualty Co. I broke my leg June 3, 1933. I told them I wanted total disability from June 3 to July 8, and partial up to August 14. They did not question anything and paid me very promptly everything my policy calls for."

Here is one from Hudson County:

"I received your check for \$57.14 in settlement of my claim for illness of recent date. I want to take this opportunity to thank you for the promptness in sending me the check. May I assure you that your action is greatly appreciated?"

Here is one from Bergen County:

"I received the second check yesterday, making a total of \$342.86 for total disability. I don't know how to thank you for your prompt payment. Certainly I never expected so light a fall to disable me this long, and I cannot thank you enough for inducing me to take out accident and health insurance. One never expects an accident, but apparently sooner or later it is inevitable in one's life.

"I feel you have a large field for salesmanship in Bergen County as yet, for I was amazed to hear many doctors, who visited me at the hospital, say they carried no protection. I can recommend this policy of our State Medical Society highly, and will do my share to let it be known what an excellent proposition it is. Again, many thanks!"

Here is one from Somerset County:

"I want to thank you for the settlement which you recently made with me on account of my accident. I have already spoken to some of my medical friends about the satisfactory way in which you have treated me. I spoke about it at the Medical Club last night and I am writing a letter to Dr. Pinneo and also the Secretary of our County Medical Society, telling them about this."

Here is one from Essex:

"I have this day received from you the balance of my claim. I want to emphasize the word 'balance,' because I wish to convey to you and the County Society that I feel your method of prepayment on a specified claim is not only useful but most humanitarian. The fact I was insured with your reputable company was a great comfort to me and my family."

(Two other counties, one the Omaha Physicians' Association, not only dallied about set-

tlement with him, but then marked him off for renewal.)

Here is another one from Essex County:

"Thank you kindly for your check of \$182.14, as payment in full in accordance with your letter of May 1, 1934; final payment to cover the period of disability."

Here is another from Essex County:

"Permit me to extend my thanks for and appreciation of your prompt settlement of my claim. Your amount is more than generous, and in these depression days is most welcome."

Here is one from a leading member of the Fourth Jersey Medical Society, the society of colored men, which held a very creditable convention in Newark, a general letter which he addresses as a circular: "Why Every Licensed Physician in the County Should be a Member of the Essex County Medical Society," and in this is this paragraph:

"The principle of group insurance which the Society has adopted has functioned advantageously to many of the members. Its group physicians' liability, casualty, and automobile policies carry special advantages which no physician should overlook. I have personally benefited once under the casualty group policy. Following an illness of about two weeks, the claim was promptly and satisfactorily paid. There are few physicians who do not need automobile protection at some time. In this connection I have benefited also."

PRESIDENT QUIGLEY: This report will be referred to the Reference Committee B, Dr. Lippincott, Chairman.

Action, Sect. 39.

26. COMMITTEE ON CONSTITUTION AND LAWS

Original report in May JOURNAL, page 292.

Now we will hear the supplemental report from the Chairman of the Committee on Constitution and By-Laws, Dr. Charles J. Murn.

Dr. Murn read his report, as follows:

SUPPLEMENTARY REPORT OF SPECIAL COMMITTEE ON CONSTITUTION AND BY-LAWS

By CHARLES J. MURN, M.D.

To the House of Delegates:

The Committee on Constitution and By-Laws has held no meeting this year.

President Quigley has suggested an amendment to Section 2, Chapter VIII of the By-Laws (page 28), which reads as follows:

"Section 2. The Standing Committees shall be:

Nominating Committee	Publication
Committee on Finance	Honorary Members
Scientific Work	Hospitals and Medical
Program and Arrangements	Education
	Welfare

It is proposed to add the words: "and such additional Committees as the House of Delegates may determine."

The last printed copy of the Constitution and By-Laws was issued in 1929, and it is recommended that a new edition, brought up-to-date, shall be prepared.

Charles J. Murn, M.D.

PRESIDENT QUIGLEY: This serves as a first reading of the proposed change in the By-Laws. If the Chairman will draft that into shape for action at the Thursday meeting, inasmuch as it is a Reference Committee itself, this recommendation will be referred back to it for action on Thursday.

Action, Sections 45 and 46.

This concludes the reports of the officers and committees.

27. REFERENCE COMMITTEES ON NEW BUSINESS

Sect. 4.

The next order of business is the introduction of New Business. Before proceeding to that, I will announce the Reference Committees to which new business will be referred:

Resolutions and Memorials: Dr. D. Leo Haggerty, Chairman; Dr. Teimer, Dr. S. Alexander, Dr. John Condon, and Dr. Robert L. McKiernan.

Committee on Miscellaneous Business: Dr. T. K. Lewis, Chairman; Dr. J. Leopold, Dr. D. M. Disbrow, Dr. Herbert M. Ill, and Dr. William G. Herrman.

The Chair is now ready for any resolutions or motions under the heading of New Business.

28. RESOLUTION ON REDUCTION OF DUES

SECRETARY MORRISON: Mr. President, there is a resolution from Hudson County,

passed February 19, 1934, recommending that the annual dues of the State Society be reduced to \$7, is as follows:

"Resolved, That it is the sense of the Hudson County Medical Society that the State dues are too high, and that \$7 maximum for the State dues be recommended, and that this motion be referred to the delegates of this County Society who shall present it to the State Society at the Annual Meeting in October."

DR. PINNEO (Essex): I move that this be laid on the table.

The motion was regularly seconded, was put to a vote and was carried (see Sect. 51).

PRESIDENT QUIGLEY: There is one report I negelected to ask for. I don't know whether the State Board of Medical Examiners has a supplementary report.

29. BOARD OF MEDICAL EXAMINERS

DR. MAGUIRE: The State Board has nothing to add other than the report submitted and already in the JOURNAL (May, p. 293).

PRESIDENT QUIGLEY: A motion to adjourn is in order.

Upon motion regularly made and seconded, it was voted to adjourn. The meeting adjourned at four twenty-five o'clock.

30. PRESIDENT'S ADDRESS

A General Meeting of the Medical Society of New Jersey was held at noon on Wednesday, June 6, 1930, according to the published program, for the purpose of hearing the Annual Address of the President, Dr. Frederic J. Quigley.

Dr. Quigley read his Presidential Address, which is published in the June Journal, page 320. This address was referred to Reference Committee A, Dr. B. S. Pollak, Chairman.

Action, Sects. 37, 38 and 48.

Wednesday Afternoon, June 6, 1934

The Second Session of the House of Delegates convened at two thirty-five o'clock, President Quigley presiding.

PRESIDENT QUIGLEY: The House will please be in order.

I regret the delay in starting this afternoon's session.

31. ELECTION OF OFFICERS

The first order of business is the report of the Nominating Committee, by Dr. Lippincott.

DR. LIPPINCOTT: The Secretary has it.

SECRETARY MORRISON: "Your Nominat-

ing Committee respectfully reports the following nominations:

President-Elect, Marcus W. Newcomb, Burlington.

First Vice-President, Francis R. Haussling, Essex.

Second Vice-President, Charles H. Schlichter, Union.

Secretary, J. Bennett Morrison, Essex.

Treasurer, Elias J. Marsh, Passaic.

Trustee for the First District (to fill the vacancy left by Wells P. Eagleton), Walter B. Mount, Essex.

Trustees for the Fourth District, A. Haines Lippincott, Camden.

Trustee for the Second District, Andrew F. McBride (re-nominated).

Trustee for the First District (to fill the place of Charles B. Smith, deceased), Lawrence Bloom, Warren.

Councilor for the Third District, F. G. Scammell (re-nominated).

Delegates to the American Medical Association, Walt P. Conway (re-nominated), John F. Hagerty (re-nominated).

Alternate Delegates to the American Medical Association, Philip Marvel (re-nominated), Lucius F. Donohoe, Hudson, to succeed George H. Sexsmith.

Committee on Scientific Work, Lewis C. Lange, Hudson (re-nominated), Clarence L. Andrews, Atlantic (to fill the unexpired term of W. Blair Stewart, deceased).

Committee on Program and Arrangements, John W. Gray, Essex (re-nominated).

Committee on Publication, Edward J. Ill, Essex (re-nominated).

Committee on Finance and Budget, W. F. Costello, Morris.

Committee on Honorary Membership, Thomas W. Harvey, Essex (re-nominated) (in place of W. E. Darnall, who is not a Fellow), F. J. Quigley, Hudson.

Committee on Hospitals and Medical Education, Arcangelo Liva, Bergen (renominated).

Respectfully submitted,
Chairman, A. Haines Lippincott
Secretary, Stephen F. Quinn.

PRESIDENT QUIGLEY: Inasmuch as the present President-Elect becomes President at the conclusion of this Annual Meeting, without process of election, the House, of course, has no voice in selecting the President. That is done by automatic succession.

Are there any other nominations for President-Elect? For First Vice-President? For Second Vice-President?

DR. SAMUEL ALEXANDER (Bergen): Mr. President and Members of the House of Delegates: I have been asked by delegates in every section of this State to place in nomination the name of a man whom we think is qualified in every way to fill that position. We feel that the report of the Nominating Committee in this instance, at least, does not represent the true feeling of the majority of the members of this House.

We are going through a very critical time, as far as the medical profession is concerned, and we feel that the next three or four years

will be even more critical for the medical men of this State, and we feel this is a time to put men at the helm of our organization who will continue with the progressive policies of the administration that we have had for the past two or three years. We feel that that is very important and we feel that the majority of the delegates in this House feel the same way.

The man I am about to nominate, as I said before, has every qualification for that position. He is an attending surgeon at the Hackensack Hospital, a Fellow of the American College of Surgeons, for the past five years he has been the Councilor for the Second District in this State, and for the past year or two he has been Chairman of the Emergency Relief Committee, which, I feel, is a most important committee, and in its functioning during the past year the Committee has done a great deal for the medical men of this State.

And so, my friends, if you feel that the man I am about to nominate has the qualifications for the position that he seeks, then I ask you to go along with Bergen County's choice, Spencer T. Snedecor, of Hackensack. (Applause).

PRESIDENT QUIGLEY: Does anyone wish to second this nomination?

DR. HERSCHEL PETTIT (Cape May): I take pleasure in seconding the nomination of Dr. Snedecor, who, I feel, has worked very hard in our interests for a long time. (Applause.)

PRESIDENT QUIGLEY: Are there any further nominations for Second Vice-President? If not, I will entertain a motion that the nominations be closed for Second Vice-President.

It was regularly moved and seconded that the nominations for Second Vice-President be closed. The motion was put to a vote and was carried.

DR. STEPHEN F. QUINN (Union): A word has been said before the assembly here in reference to Dr. Snedecor. May I be allowed to say a word in favor of Dr. Schlichter?

PRESIDENT QUIGLEY: I am afraid not. I shall have to rule that out of order. The Nominating Committee has made its nominations and the qualifications of the candidates have been presented to the Nominating Committee.

DR. THOMAS B. LEE (Camden): There has been not only implied but stated criticism of the Nominating Committee's choice and if it is the pleasure of this company, I should like to take about two minutes to say something on this now.

PRESIDENT QUIGLEY: I have heard no criticism, Dr. Lee. I think that the remarks

would not be in order. The nominations are already in as a report of the Committee and, of course, this will set a precedent, if it is done. There will be ten or twelve who will have the same privilege. I personally have heard nothing that was any reflection on the work of the Nominating Committee.

DR. EPHRAIM R. MULFORD (Burlington): I move that Dr. Lee be given the privilege of the floor.

The motion was seconded.

PRESIDENT QUIGLEY: If there is no objection, if Dr. Lee's thought is that he will represent the opinion of the Nominating Committee—I take that is your thought, Dr. Mulford?

DR. MULFORD: No, I think my thought is that the House of Delegates would like to hear what Dr. Lee has to say on the nominations for Second Vice-President.

PRESIDENT QUIGLEY: I want to be, of course, absolutely fair in this thing, but we must proceed according to parliamentary procedure, and I am afraid if I entertain that motion, a similar motion can be made for fifteen others. If you will show me some good reason, or parliamentary point, all right; if not, I think I shall have to decline to entertain the motion.

DR. LEE: The meeting has already decided that it will hear me.

PRESIDENT QUIGLEY: No action has been taken on Dr. Mulford's motion.

DR. MARAS (Hudson): I arise to a point of order. The doctor is, in my opinion, entirely out of order. I have no criticisms to make of the Nominating Committee, and so on, but inasmuch as the Nominating Committee's slate has been tendered, and inasmuch as the nominations for Second Vice-President have been closed according to parliamentary procedures, as I understand it, that question is closed, Mr. President.

PRESIDENT QUIGLEY: Your point is well taken. The motion is out of order.

DR. LEE: Mr. President, may I ask this? The Nominating Committee did its work as well as it could. It made no speeches before this House, and may I suggest that any further names offered in nomination may be offered without making speeches, because the candidates offered by the Nominating Committee have not the privilege of being extolled on the floor before the Assembly?

PRESIDENT QUIGLEY: I shall have to deny that request because the opportunity for bringing them to the attention of the Society has already been made in the Nominating Com-

mittee, I presume, with whatever remarks that were appropriate to the proposal of any of the candidates.

Are there any other nominations for Secretary? For Treasurer? For Trustees? I should like to go over this: First, to fill the unexpired term of Dr. Charles B. Smith, to extend to 1936. Dr. Smith died during the year. This is for nomination of "Trustee-at-large." The By-Laws provide that each Judicial District shall have at least two Trustees. There are eleven elected Trustees. Of the eleven, two must come from the Fellows. At the present time the First Judicial District has two Trustees in the persons of Dr. Green, of Union, and Dr. Eagleton, of Essex. They had a third in the place of Dr. Smith, who died during the year.

Dr. Green and Dr. Eagleton were both nominated and elected as representatives of the First Judicial District; therefore, the nominations to fill the unexpired term of Dr. Smith may come from any Judicial District in the State.

Do I hear any further nominations to fill the unexpired term of Dr. Charles B. Smith?

DR. JAMES S. GREEN (Union): I should like to correct the statement made. I was distinctly elected as a representative of the Fellows and not of my district, and the records will so show.

PRESIDENT QUIGLEY: I made that plain. It makes no difference whether you were elected a representative of the Fellows or not, there must be two from each Judicial District, regardless of where they come from. It happens that in your instance, you are a Trustee who was selected by the Fellows. That name was then transmitted to the Nominating Committee and, according to the By-Laws must be brought in as one of the nominees from that district. That gives one Trustee from that district.

Dr. Eagleton was not a Fellow representative, but was elected—was nominated by the Nominating Committee, and elected by the House.

Are there further nominations to fill the unexpired term of Dr. Charles B. Smith?

DR. B. T. D. SCHWARTZ (Hudson): Mr. President and Fellow Delegates: There are many men in this Society who could very creditably represent us in the office of Trustee, but if you are to consider experience, long labor on behalf of the medical practitioners of this State and of this Society; if you are to consider a record of achievement, progressive achievement in this Society, then I think that you will agree that there is none

more fitted than Dr. Frederic J. Quigley. (Applause).

PRESIDENT QUIGLEY: Are there any further nominations for the unexpired term of Dr. Charles B. Smith? If not, I will declare that the nominations are closed to fill the unexpired term of Dr. Smith as a Trustee.

Are there any further nominations to succeed Dr. Wells P. Eagleton, of the First District?

DR. E. ZEH HAWKES (Essex): Mr. President and Members of the Society: The man whom I wish to nominate requires no introduction or eulogy from me. You all know that he is a fearless fighter for what he believes to be right, and that he is always ready to give the best that is within him to advance the interests of the medical profession.

I speak here not as an individual but as a representative of the delegation of the county from which I come. Essex County has the largest membership of any county in the State. We have approximately one-quarter of all the membership of this Society. We, therefore, think it is due us to have representation in the Board of Trustees. We believe that we should be represented in the Board of Trustees and should be represented by the man of our choice. The Essex County delegation is unanimous in presenting the nomination of Dr. Wells P. Eagleton. (Applause).

DR. WALTER B. MOUNT (Essex): I second that nomination and, Mr. President, I should like to withdraw my name from the nomination that was suggested by the Nominating Committee, which nomination was made without my knowledge and without my having been asked about the matter. (Applause).

PRESIDENT QUIGLEY: Dr. Mount having declined the nomination, his name is withdrawn. Are there further nominations? I declare the nominations closed.

Are there any further nominations to succeed Dr. Andrew F. McBride, of the Second District, as Trustee?

DR. WILLIAM G. HERRMAN (Monmouth): May I rise to a point of order? The nomination of Frederic J. Quigley was not seconded.

PRESIDENT QUIGLEY: It is not necessary. A nomination need not be seconded.

Are there any further nominations to succeed Dr. Andrew F. McBride? If not, I will declare the nominations closed.

Are there any further nominations to succeed Dr. Harold B. Disbrow, of the Fourth Councilor District as Trustee?

DR. JAMES A. FISHER (Monmouth): Mr.

President and Members of the House of Delegates: I wish to present before you the name of Dr. Harold Disbrow, to succeed himself as a Trustee from our Councilor District, of which I happen to be the Councilor. He is from Lakewood and that is a section that needs representation on the Trustees of the County of Ocean. He has served very faithfully on the Board of Trustees and has been very strict in his attendance except during a period of illness, and I believe that in Dr. Disbrow we have a very valuable man, a leader in his own community, an able surgeon, and one who can well represent the Society in the Board of Trustees. (Applause.)

DR. EUGENE G. HERBENER (Ocean): I should like to second the nomination of Dr. Harold Disbrow. I come as a Delegate of Ocean County and they will be more than pleased to have him continue as the Trustee to the State Society. (Applause).

PRESIDENT QUIGLEY: Are there any further nominations to succeed Dr. Disbrow? If not, I will declare the nomination closed.

Councilor of the Third District to succeed Dr. Frank G. Scammell. Are there further nominations? If there are not, I declare the nominations closed.

For Delegates to the American Medical Association, to succeed Dr. Walt P. Conaway. Are there any further nominations? If not, nominations are closed, to succeed Dr. Conaway. Are there any further nominations to succeed Dr. John F. Hagerty? If not, I declare the nominations closed.

For Alternates to the American Medical Association, to succeed Dr. Philip Marvel—are there any further nominations? If not, the nominations are declared closed. To succeed Dr. George H. Sexsmith, as Alternate, are there any further nominations? If not, I declare the nominations closed.

Standing Committees: Committee on Scientific Work, to succeed Dr. Lewis C. Lange. Are there further nominations? If not, I declare the nominations closed.

To succeed Dr. Clarence L. Andrews, ad interim appointee. Are there any further nominations? If not, I declare the nominations closed.

Committee on Publication, to succeed Dr. Edward J. Ill—any further nominations? If not, I declare the nominations closed.

Committee on Finance and Budget, to succeed Dr. Alfred Stahl—any further nominations?

DR. WILLIAM H. ARESON (Essex): On this very important committee we have had representatives from Essex for a number of

years and we are here to endorse that work. Look at the Treasurer's report for this year and it shows a very nice balance, and we feel our representative has had something to do with it in the Budget and Finance Committee.

It is with pleasure that we ask that Dr. Alfred Stahl be returned to the Finance and Budget Committee. (Applause).

PRESIDENT QUIGLEY: Does anyone desire to second the nomination?

DR. H. ROY VANNESS (Essex): I should like to second the nomination of Dr. Stahl, who is the unanimous choice of the Essex delegation.

PRESIDENT QUIGLEY: Are there any further nominations? If not, I will declare the nominations closed on a successor to Dr. Alfred Stahl as a member of the Committee on Finance.

Committee on Program and Arrangements, to succeed Dr. John W. Gray—are there further nominations? If not, I will declare the nominations closed.

Committee on Honorary Members, to succeed Dr. Thomas W. Harvey—are there any further nominations? I think there is a second one to succeed Dr. Darnall.

SECRETARY MORRISON: Yes, F. J. Quigley.

PRESIDENT QUIGLEY: To succeed Dr. W. E. Darnall—are there further nominations? If not, I will declare the nominations to succeed Dr. Thomas W. Harvey and Dr. W. E. Darnall, closed.

Committee on Hospitals and Medical Education, to succeed Dr. Arcangelo Liva—are there any further nominations? If not, I will declare the nominations closed.

We will now proceed to ballot and I shall appoint as Tellers Dr. Lewis, of Camden; Dr. Morris, of Union; Dr. Sprague, of Essex; Dr. Sweeney, of Hudson; and who is there here from Atlantic—Dr. Andrews.

I suggest that the Chairman of the Committee on Credentials sit with this committee to check the members of the House of Delegates entitled to vote. The voting will be by a roll call of the delegates by counties. This is a closed vote by ballot. The names of the members nominated by the Nominating Committee will be placed upon the blackboard, as well as those nominated from the floor. I was advised this morning that there would be a contest and so the ballot contains a place to vote for the successors to the various positions, but there is one error in it. There is an addition to the Committee on Honorary Members. It contains one name, to succeed Dr. Thomas W. Harvey. There also is a vacancy to succeed Dr. Darnall, who inadvertently

was placed on the Committee last year, but inasmuch as he is not a Fellow, he is not eligible, according to the By-Laws; and so will you remember that you have two to vote on for members of the Committee on Honorary Members.

I will ask Dr. Lewis and the Tellers to pass the ballots to the delegates.

DR. QUINN: I rise to a point of order. As Secretary of the Nominating Committee, I want to say we have transmitted a printed report of the Nominating Committee, which states that for the Committee on Honorary Membership there is Dr. Thomas W. Harvey, renominated; and in place of Dr. Darnall, the name of Dr. Quigley.

PRESIDENT QUIGLEY: That has already been mentioned, and it will be placed upon the board. Your point is well taken. It was done inadvertently in printing the ballots. I will ask the House to take a five-minute recess while the Tellers organize for their work.

Recess.

PRESIDENT QUIGLEY: It has been suggested that a motion be made that the Secretary cast a ballot for all officers and members of Standing Committees where there is no contest, which would mean in the case of Dr. Eagleton that he is now the nominee of the Society, and if the motion is made and prevails, he will be elected. Also any nominees for vacancies in Standing Committees which are recommended by the Nominating Committee, will likewise be elected. Do I hear such a motion?

DR. STEPHEN F. QUINN: I make a motion that the Secretary cast the ballot for the officers in which there is no contest, voting for those nominated by the Nominating Committee and including the nomination of Dr. Eagleton, inasmuch as Dr. Mount has withdrawn.

The motion was regularly seconded, was put to a vote, and was carried. Secretary Morrison reported having cast the ballot, and President Quigley declared the list of nominees recommended by the Nominating Committee, on which there was no contest, elected. The list follows:

President-Elect, M. W. Newcomb.

First Vice-President, Francis R. Haussling.

Secretary, J. Bennett Morrison.

Treasurer, Elias J. Marsh.

Trustees, First District, Wells P. Eagleton.

Trustee, Second District, Andrew F. McBride.

Councilor, Third District, F. G. Scammell.

Delegates to A. M. A., Walt P. Conway, John F. Hagerty.

Alternate Delegates to A. M. A., Philip Marvel, Lucius F. Donohoe.

Committee on Scientific Work, Lewis C. Lange, Clarence L. Andrews (to fill unexpired term of W. Blair Stewart, deceased).

Committee on Program and Arrangements, John W. Gray.

Committee on Publication, Edward J. Ill.

Committee on Hospitals and Medical Education, Arcangelo Liva.

Committee on Honorary Membership, Thomas W. Harvey, Frederic J. Quigley.

PRESIDENT QUIGLEY: Will the Tellers distribute the ballots?

DR. LEWIS: They are all distributed.

The House proceeded to cast their ballots.

PRESIDENT QUIGLEY: Has everyone voted who is entitled to vote? If so, I declare the ballot closed.

Will the Tellers retire to tally the vote, and when the count is completed return to announce the results.

The Tellers retired.

PRESIDENT QUIGLEY: We will now hear the Report of the Tellers on the Election. Dr. Lewis, are you ready to report?

DR. LEWIS: Dr. Morrison has the report.

SECRETARY MORRISON: "The following report is submitted by the Tellers:

191 ballots cast.

1 ballot void.

Second Vice-President:

Schlichter 93

Snedecor 98

Trustee Fourth District:

Lippincott 90

Disbrow 98

Trustee-at-Large:

Bloom 71

Quigley 119

Financial Committee:

Costello 85

Stahl 100

T. K. Lewis, Chairman,
W. B. Morris
William J. Sweeney
Edward W. Sprague
Clarence L. Andrews."

(Applause).

PRESIDENT QUIGLEY: For Second Vice-President, Dr. Snedecor having received 98 votes, against 93, I declare Dr. Snedecor elected Second Vice-President of this Society. (Applause).

For Trustee for the Fourth District, Dr. Disbrow having received 98 votes, I declare Dr. Disbrow elected.

With rather unbecoming modesty, I have to declare myself, having received 119 votes, elected Trustee-at-Large.

For the Finance Committee, Dr. Stahl having received 100 votes, I declare Dr. Stahl elected a member of the Finance Committee. (Applause).

The meeting adjourned at four-fifteen o'clock.

Thursday Afternoon, June 7, 1934

The meeting convened at two-fifteen o'clock, President Quigley presiding.

32. OFFICIAL MASCOT, MISS HELEN

HOPE HAGGERTY

PRESIDENT QUIGLEY: The House will please come to order.

Before proceeding to the regular order, I should like to say a word. Of course, as an organization we feel that we are making a fairly good record because of good team play. Almost all teams have a mascot, and it has occurred to me that we ought to conform to a custom among teams and have an official mascot, so I am going to offer the suggestion that this young lady (her father, by the way, has brought us good luck as Chairman of the Sub-Committee on Legislation of the Welfare Committee) be made our official mascot.

This young lady is Miss Helen Hope Hag-

gerty, and I suggest she be nominated as the official mascot of the One Hundred and Sixty-Eighth Annual Meeting of the Medical Society of New Jersey. (Applause).

DR. CONNOLLY (Essex): May I have the honor and pleasure of nominating Miss Helen Hope Haggerty as official mascot of the Medical Society of New Jersey?

DR. NORTH (Mercer): I should like to have the honor of seconding this nomination. Helen Hope is my best girl. Isn't that right, Helen Hope?

PRESIDENT QUIGLEY: The motion has been made and seconded that Miss Helen Hope Haggerty be and is hereby officially designated as the official mascot of the One Hundred and Sixty-Eighth Meeting of the Medical Society of New Jersey. All in favor of the motion signify by saying aye; contrary, no; it is so ordered. Miss Helen Hope, just as a little souvenir, will you accept this little bouquet. (Applause).

MISS HELEN HOPE HAGGERTY: Thank you! (Applause).

33. CANCER COMMITTEE OF THE SOCIETY, DR. EDWARD J. ILL.

PRESIDENT QUIGLEY: It requires unanimous consent for the introduction of new business, inasmuch as this is the last meeting of the House of Delegates. Under new business at the first meeting was designated a suggestion to come from Dr. Edward J. Ill as to the formation of a Cancer Committee of the State Society. This matter was brought to the attention of the Trustees about six or seven weeks ago by Dr. Ill, who, as you know, has for many years headed the State Committee of the Association for the Control of Cancer. The Trustees felt that this was very desirable, and suggested that Dr. Ill go ahead with the movement, and also authorized him to appoint such committee as he felt desirable, inasmuch as he was familiar with the men of the State who were particularly interested in cancer control. We felt that this subject was of sufficient moment to warrant its being brought to the attention of the House of Delegates.

Is there any objection to the introduction of this subject at this time? If not, Dr. Edward J. Ill, of Newark! (Applause).

DR EDWARD J. ILL: To bring this properly before you. I should like to offer the following preambles and resolutions:

"Whereas, The rapid increase of cancer in its various forms has now placed it second only to heart disease as a major cause of death; and

(Let me say last year the Widows and Orphans' Society lost twelve members. Among these were eight who died of heart trouble and four of cancer.)

"Whereas, The present status of cancer is a challenge from an humanitarian standpoint, to the medical profession to render an increasingly effective service in diagnosis and treatment; and

"Whereas, The greatest hope of reducing the increasing mortality from this group of diseases lies in the early stages; and

"Whereas, The public through education is becoming more and more insistent upon availability of facilities where these fundamentals in the management of cancer cases can be fulfilled; and

"Whereas, The medical profession and the hospitals are the only forces capable of furnishing the needed services in this field, and must assume the full responsibility for the immediate initiation and conduct of this service; therefore be it

"RESOLVED, That the New Jersey State Medical Society endorse the programs of the American College of Surgeons and the American Society for the

Control of Cancer for organization of Cancer Services in general hospitals and for education in this field; and further be it

"RESOLVED, That the New Jersey State Medical Society shall appoint a Committee on Cancer whose function it shall be to survey the existing conditions and stimulate the interest in the movement for cancer control in accordance with these programs or in accordance with such modifications thereof as will best meet the needs of the State."

The object of presenting these resolutions is to increase the general interest in the control of cancer. Several of our counties have done most excellent work in the study of cancer. Their efforts and results might well be copied by the State as a whole. To progress, it naturally must begin with the physician who rarely sees a case. To bring before him the facts of early diagnosis must be ever in one's mind. To learn of the true status only when it is too late for a proper and efficient treatment is not only a harmful thing to the physician in charge, but also detrimental to the patient and his dissatisfied family. That the education and a fair knowledge may be carried on both to the laity and the physician, we suggest the appointment of a committee by the President of one from every Consular District and several consulting pathologists from the State as a whole. (Applause.)

PRESIDENT QUIGLEY: I will entertain a motion that a committee be appointed headed by Dr. Ill, and that he be authorized to select a committee from the Councilor Districts in conformity with the suggestions contained in these resolutions, and also that the program that he advances for the Cancer Committee be put into effect. Do I hear such a motion?

DR. ULLMAN: I so move. (Seconded.)

DR. ILL: Mr. President, may I suggest that the chairman appoint another chairman for this thing, as the work is going to be tremendous, and I have been reminded of my age since last evening. (Laughter).

PRESIDENT QUIGLEY: I think the Society would like to have you act as chairman and be relieved by somebody as vice-chairman, who can take over some of the details. I think we feel that the movement will gather greater headway if it has you as chairman. I think I am interpreting the sentiment of the Society.

The motion was put to a vote and was carried.

PRESIDENT QUIGLEY: We will proceed to the reports of the Reference Committee presently, but before doing so I will ask Dr. Morrison to read this telegram:

34. GREETINGS FROM THE NEW JERSEY HOSPITAL ASSOCIATION

Secretary Morrisson read the following telegram:

The New Jersey Hospital Association sends greetings and cordial invitation to attend its Tenth Annual Convention, Haddon Hall, tomorrow and Saturday. May our friendly relations ever continue.

Marie Louis, R. N., President,
New Jersey Hospital Association.

(Continued after Section 35)

35. REGISTRATION

SECRETARY MORRISON: While I am on my feet, may I call your attention to the fact that the combined registration of delegates and members is 515, and that is the largest number of physicians who have ever attended a convention in New Jersey in the eleven years of my service. (Applause).

See Section 2.

SECTION 34 CONTINUED

PRESIDENT QUIGLEY: Will someone move that the invitation of the New Jersey Hospital Association be accepted with thanks and that a telegram to this effect be sent to the President of the Association?

DR. B. S. POLLAK (Hudson): I so move.

The motion was regularly seconded, was put to a vote, and was carried.

36. REPORTS OF REFERENCE COMMITTEES

PRESIDENT QUIGLEY: The reports of the Reference Committees are combined with new business, and it probably will be better to have the reports of each of the committees read and then the recommendations contained therein taken up one by one before proceeding to the next Reference Committee report. I call for a report from Reference Committee A, Dr. B. S. Pollak, Chairman.

37. REFERENCE COMMITTEE A TRUSTEES

Sect. 10.

PUBLICATION COMMITTEE

Sect. 17.

PRESIDENT'S MESSAGE

Sect. 30.

DR. B. S. POLLAK: Mr. President and Members of the House of Delegates: I beg to report to you concerning a meeting which was held by the Reference Committee A ap-

pointed by President Quigley, four of the members being present, the fifth member could at no time be found, Dr. Featherston.

Dr. Pollak read the Report of Reference Committee A, as follows:

REPORT OF REFERENCE COMMITTEE "A"

To the Delegates of the Medical Society
of New Jersey in Convention Assembled:

Gentlemen:

Reference Committee A, appointed by the President, met, and begs leave to report that it has carefully examined into the report of the Board of Trustees (Section 10), the Publication Committee (Section 17), and the President's Address (Section 30), and reports as follows:

The Committee recommends that the nine points specified in the Trustees' Report be adopted. (Section 10.) The Committee unanimously approves the suggestion of the Board of Trustees that the position of Chairman of Board of Trustees not extend over two terms.

Likewise, it approves the suggestion that all paid employees of the Board of Trustees be subjected to the jurisdiction of the President, except the Editor of the Journal, who is under the jurisdiction of the Publication Committee in conjunction with the Board of Trustees.

It further approves the position of the Board in divorcing the position of the Editor of the Journal from the position of Executive Secretary. The Committee feels it desirable and wise to emphasize the value of divorcing these two positions. This arrangement greatly benefits the Society because, among other reasons, it provides greater efficiency and greater and surer results.

Your Committee is in entire accord with the general principles enunciated in the President's Address (Section 30), and particularly realizes with him the apparent imminence of a crisis in the affairs of organized medicine, and is pleased to note the two topics especially emphasized.

The President's concern regarding the welfare of the doctor is outstanding and evidences a thorough understanding of the present status of organized medicine. The contents of his message are replete with sound logic, and a critical analysis thereof finds its best interpretation in the fact that organized medicine's chief purpose is to serve humanity. This, whilst apparently considered as an idealistic attitude, is brought home by practical suggestions and recommendations, and that the solution of the present condition of the status of the doctor must be met by concentrated effort and coöperation is apparent; and inasmuch as this condition applies generally to our profession, it is obvious that sporadic or individualistic effort will not avail. Hence, the conclusion arrived at and offered to us and the medical profession generally is an inevitable one.

We appreciate the emphasis that unless the parent body of organized medicine, the American Medical Association, immediately assumes the leadership to meet the greatest threat that has ever been made to American Medicine, our high purposes, our

striving for the nobler things in life, our altruistic concept concerning our duties and responsibility toward the American public shall have been in vain.

We especially approve that portion of the President's Message which clearly places the responsibility of solidifying our forces of suggestions, of plans and scope at the fountain head of American Medicine—the American Medical Association; and, therefore, we unreservedly favor the adoption of the suggestion of the President that this House of Delegates hereby requests its elected representatives to the American Medical Association to present at the meeting of the American Medical Association on June 11th, 1934, at Cleveland, a set of resolutions expressing the sentiments of this House of Delegates relative to the urgency which exists and which requires definite action, meeting the issue squarely along the lines so clearly and emphatically advocated by the President in his forceful and diplomatic resumé of the entire problem. We congratulate the President for the excellence of his address and rejoice with him for having been able to submit for the edification of the medical profession so splendid a document in the form of the Presidential address which in scope and effect visualized the true status of organized medicine.

Respectfully submitted,

REFERENCE COMMITTEE A

B. S. Pollak, M.D.

Thomas B. Lee, M.D.

James J. McGuire, M.D.

D. Ward Scanlan, M.D.

PRESIDENT QUIGLEY: What is your pleasure with respect to the Report of Reference Committee A? Do you wish it to be divided, or what is your thought? Was it your thought that the report be adopted and suggestions contained therein be followed?

DR. SAMUEL ALEXANDER (Bergen): I move its adoption.

The motion was seconded by Dr. William H. Areson, of Essex.

QUESTION: Did you make any reference to the Publication Committee's report being adopted?

PRESIDENT QUIGLEY: And also the Publication Committee—the recommendations of the Reference Committee is that these reports be adopted. Are you ready for the question?

The motion was put to a vote and was carried.

38. COMMUNICATION TO THE AMERICAN MEDICAL ASSOCIATION

PRESIDENT QUIGLEY: Do you wish this Reference Committee to formulate a set of resolutions in harmony with its recommendations regarding the communication to be submitted to the delegates of this Society, and to

go to the American Medical Association with the direction of the House of Delegates that the delegates present them and attempt to further them at the meeting of the House of Delegates of the American Medical Association?

SECRETARY MORRISON: May I speak on that for a moment? Perhaps I have made a more thorough study of the dangers of socialized medicine than anyone in the House of Delegates. I have traveled over the state for the last five or six years, like a prophet in a wilderness, endeavoring to point out the handwriting on the wall. I have been called visionary, an advocate of socialized medicine, and all sorts of things by unthinking people, but the threat has been here constantly for five years and today we are face to face with the proposition and the understanding that at the next session of Congress a measure providing for social insurance will be introduced.

We must line up the medical profession in the United States 100 per cent behind some plan that will present the interests and ideas of the medical profession in the preparation of that bill. Let me tell you in the British Empire it took the medical profession fifteen years to secure the amendments that should have been written into the original act.

For five years in my trips to Chicago at the Conference of Secretaries, I have been hammering at Olin West and the members of the Conference to have the American Medical Association take the initiative in a study of the plan and outline the policy and have it ready when the time came for action. They have always replied that it should initiate in some State Society; if possible, let it originate in the Medical Society of New Jersey.

There are several things we should state. One idea is that the state should provide for the medical care of all indigents; and if that is done, the physicians may reduce their charges to the average member of the so-called white collar class.

There are four other propositions I want to suggest. The first is that the medical profession should have the American Medical Association present to the members of Congress the idea that the medical profession should be given adequate remuneration for their services, in order that those services rendered may be of the highest degree. The second is that no second party, society, or association, should intervene between the physician and his patient. That is still one of the curses of the administration in England. The third is that in the payment for the loss of time, on the part of the ill patient, that loss of time should

be entirely taken out of the hands of the panel doctor, that the patient should be examined by a separate board and a physician not a member of the panel, in order to determine what money should be appropriated to him for lost services. The fourth is in whatever board of control is set up, the physicians in the respective states should be in a majority. (Applause.)

PRESIDENT QUIGLEY: As President, of course, it isn't my function to participate in any debate on this, but I want to say a word in explanation of the recommendations contained therein. It is quite true that Dr. Morrison has gone around the state for the last five years pointing out the imminent danger and the likelihood of compulsory health insurance; but the trouble has been with us, as with every other state, that we haven't taken the initiative to call upon the fountainhead of organized medicine to meet this, and, as I pointed out in my address, it cannot be done by forty-eight different states proposing forty-eight different plans. The plan has to be formulated by a representative group acting for the whole profession.

I don't believe that compulsory health insurance is the thing for us to accept at all; but I think we have got to propose and foster a plan which will meet the changed social conditions and will make impossible the setting up of compulsory health insurance.

Is there any further discussion?

The motion was made and seconded that Reference Committee A draw up a set of resolutions together with instructions of this House that the delegates of this Society will present these to the House of Delegates of the American Medical Association at the meeting starting next week, incorporating the concepts embraced in the message of the President as to the procedure to be followed by the American Medical Association in organizing their forces and assuming the leadership to meet this threat of control of medicine by the state.

Are you ready for the question?

DR. POLLAK: I haven't had the opportunity to consult with the members of the committee. I am merely looking into the face of one of the members of the committee and he is shaking his head rather ominously. I wonder whether it would be the proper thing for us to be designated as a committee without first referring back to this organization these resolutions, because, while it is very simple to draw up resolutions, we recognize the inherent responsibility therein, and we think, or at least I think, and I am trying to think for the committee, that it might be perhaps a better scheme

that we may be permitted to retire, if the committee is here (I only see one member here), and in the latter part of the day report these resolutions rather than to have you entrust us with so tremendous a job, which may not in every detail measure up to the high expectations which such resolutions should carry with them.

PRESIDENT QUIGLEY: If there is no objection, the committee may retire and deliberate upon these resolutions and report back a little later. Is there any objection? Hearing none, it is so ordered. (Further report in Section 48.)

Is Dr. Lippincott here, or any of the members of Reference Committee B?

39. REPORT OF REFERENCE COMMITTEE B INSURANCE, HEALTH AND ACCIDENT

Sect. 25.

TREASURER

Sect. 12.

BUDGET AND FINANCE COMMITTEE

Sect. 11.

EXECUTIVE SECRETARY

Sect. 8.

SECRETARY MORRISON: I have the Report of Reference Committee B.

PRESIDENT QUIGLEY: To this committee were referred the Reports of the Finance Committee and that of the Treasurer.

Secretary Morrison read the Report of Reference Committee B, as follows:

REPORT OF REFERENCE COMMITTEE "B"

June 7, 1934

This committee has carefully considered matters referred to it:

1. Health and Accident Insurance. We approve of the report of this committee and urge physicians to consider favorably placing their insurance through the State Medical Society.

2. Treasurer's Report. No suggestions to make.

3. Budget Report. No suggestions to make.

4. Executive Secretary's Report. No suggestions to make.

(Signed) A. Haines Lippincott,
Chairman.

PRESIDENT QUIGLEY: A motion to accept the Report of Reference Committee B on the matters referred to it is in order.

DR. ULLMAN: I so move.

The motion was regularly seconded, was put to a vote, and was carried. (See also Section 50 for action on dues.)

PRESIDENT QUIGLEY: It is adopted. Reference Committee C, Dr. Quinn.

40. REPORT OF REFERENCE COMMITTEE C
PROGRAM AND ARRANGEMENTS
Sects. 3, 43, and 44, and May Jour., p. 272.

SCIENTIFIC WORK AND EXHIBITS
May Jour., p. 269.

MEDICAL EDUCATION
Sect. 19.

SECRETARY MORRISON: I have that report.

Secretary Morrison read the Report of Reference Committee C, as follows:

REPORT OF REFERENCE COMMITTEE "C"

To the House of Delegates:

Your Reference Committee C would respectfully report that we commend the *Committee on Program and Arrangements* in their saving by adopting a more modest style of program.

We would respectfully suggest to the *Committee on Scientific Work* that the Committee arrange that exhibitors of scientific exhibits announce certain hours during the meeting to explain their exhibits and have same posted with exhibit.

Your committee endorses and commends the work of the *Committee on Medical Education* and we feel that its work in offering post-graduate opportunities should be supported by the Society.

We endorse the action of the committee in their efforts to bring a closer relationship between the medical and pharmaceutical professions which, in our opinion, will redound to the benefit of our patients, the pharmaceutical and medical professions. The committee has shown commendable zeal in arranging post-graduate clinical opportunities in New York and Philadelphia medical centers which offers to our young men in the profession an open door for further scientific development.

We endorse the efforts of the committee to raise the standards of the nursing education in the state with provision for post-graduate and university education. The committee has done exceptional work in establishing post-graduate programs conducted by the Medical Society of New Jersey in cooperation with Rutgers University and we feel that this movement should have the wholehearted support of the Society.

Stephen T. Quinn, Chairman
R. M. A. Davis
Joseph I. Mark

PRESIDENT QUIGLEY: You have heard the Report of Reference Committee C. What is your pleasure?

DR. EDWARD J. MORRIS (Union): I move that it be received and the recommendations adopted.

The motion was regularly seconded, was put to a vote, and was carried.

41. REPORT OF REFERENCE COMMITTEE D
EMERGENCY RELIEF ADMINISTRATION
Sect. 18.

WORKMEN'S COMPENSATION
Sect. 22.

MEDICAL PRACTICE
Sect. 20.

HOSPITALS
Sect. 19.

PRESIDENT QUIGLEY: Reference Committee D, Dr. George D. Tracy, Chairman.

DR. GEORGE D. TRACY (Burlington): This is the report.

REPORT OF REFERENCE COMMITTEE "D"

To the House of Delegates:

Herewith follows report of Reference Committee D on committee reports assigned for its consideration.

Regarding the report of the *Medical Advisory Committee* to the New Jersey State Emergency Relief Administration, we commend the committee for its untiring efforts in dealing with the many problems involved and the ever changing regulatory provisions.

While some of the profession may consider this dolo of free medical care a radical departure which threatens some of the present standards of medical practice, we recommend that the committee be continued for one year at least, or until it shall declare the emergency has ceased; also that the committee be empowered to enter into an extension of its agreement with the Emergency Relief Administration.

While in some localities this work is not needed, there are locations where the physicians have been badly hit and it is incumbent on the members as a whole to consider this side of the case.

The profession must remember that if we do not play fairly that the State can contract this work much more cheaply than it is being done at present.

The report of the Sub-Committee on *Workmen's Compensation* demonstrates that an exhaustive and detailed study of this problem has been made and is most praiseworthy.

All recommendations are approved, as a remedy is suggested for correcting many of the defects of our present Compensation Law. The committee should certainly be continued, and we further recommend that a bill be prepared for early introduction in the next session of Legislature for the more efficient functioning of our Compensation Law.

The report of the Sub-Committee on *Medical Practice* reveals the many ramifications encountered, which certainly concerns every one of us, including hospitals, dentists, pharmacists and nurses, so congratulations are certainly in order for this painstaking study by the committee.

Your Reference Committee suggests some minor changes in the printed report submitted to the delegates as follows:

Under heading—Standards for Dispensaries—we suggest that section 3 be omitted as this question seems to be fully covered in Section 5.

Section 4, sub-heading (a) under Personnel of Dispensaries—to read as follows: Physicians qualified in their particular branch, or who are so training.

Under sub-heading (b), suggesting a whole time nurse for the dispensary, we feel this should be modified but make no definite suggestions at this time.

Section 5—on the eighth line of the paragraph, after the word "Physician" insert—"or the proper authorization from a suitable agency. In localities where the ideal set-up cannot be installed, the best possible rules between the hospital and staff should be arranged."

Under section 7 of Standards, we suggest that the last sentence be made to read as follows: All drugs, vaccine, sera, etc., to be dispensed at cost, or a charge of 15 cents may be made by the dispensary. Special medical facilities used in treatment, such as physiotherapy, etc., should be at a nominal cost.

We concur in hearty endorsement of the plans suggested by this committee, believing them to be sound and sensible, and that if put into operation will help solve many of our difficulties.

Physicians should keep in mind, however, that much work referred to hospitals can be done by the properly equipped and intelligent physicians.

The Conference of the Allied Professions of New Jersey sponsored by this committee is another forward step in organized medicine and deserves our hearty support. We, therefore, approve of this recommendation by the committee.

Inasmuch as the report of the Committee on Hospitals has been submitted to the Board of Trustees to make certain changes before their final adoption, we will wait the Trustees' action in the matter.

Respectfully submitted,

E. J. Chapman
W. F. Costello
Leslie E. Myatt
Edward W. Sprague
George T. Tracy,
Chairman.

PRESIDENT QUIGLEY: You have heard the report. Of course, the matters referred to are very important. Is there anyone who wishes to make any motion with reference to any portion of the report? If not, I will entertain a motion that the Report of the Reference Committee be adopted.

DR. ULLMAN: I so move.

The motion was regularly seconded.

PRESIDENT QUIGLEY: It has been regularly

moved and seconded that the report and the recommendations of the Committee D on matters referred it be adopted.

The motion was put to a vote and was carried.

PRESIDENT QUIGLEY: Reference Committee E, Dr. E. Zeh Hawkes, of Essex.

42. REFERENCE COMMITTEE E.

DELEGATES TO AMERICAN MEDICAL ASSOCIATION

Sect. 14.

LEGISLATION

Sect. 22.

UNIFORM MEDICAL PRACTICE ACT

Sect. 23.

PHYSICIAN'S LIEN ACT

Sect. 24.

BOARD OF MEDICAL EXAMINERS

Sect. 29.

DR. E. ZEH HAWKES: Mr. President and Members: The Chairman of this Committee having had no previous experience with this line of work, wants to state to you that he is under very great obligation to his co-workers on the Committee, Dr. Morris, Dr. Sweeney, Dr. Watkins and Dr. Lawton.

Dr. Hawkes read the Report of Reference Committee E, as follows:

REPORT OF REFERENCE COMMITTEE "E"

ON THE SUB-COMMITTEE ON PHYSICIANS' LIEN ACT

This committee has given careful study to the Act, especially to its provision that a fee scale be established, without having reached any final conclusion. Inasmuch as the fee scale before adoption must be approved by the Court, after the various interested parties—that is, the medical profession, the insurance carriers and the bar association have been heard—we recommend that the committee be continued and that it be instructed to endeavor to reach an acceptable fee scale by joint agreement in conference with representatives of the insurance carriers and the Bar Association, and to report by or before July 1st, 1934, to the Board of Trustees of the Medical Society of New Jersey, who shall be empowered to decide the fee scale for the Medical Society of New Jersey.

ON THE SUB-COMMITTEE ON UNIFORM MEDICAL PRACTICE ACT

A resolution was made, that the Sub-Committee Report on Uniform Medical Practice Act is very specific and satisfactory and that Reference Committee "E" endorses it with the recommendation that it be adopted by the House of Delegates.

It was also recommended that the work of the committee be continued and that the Board of Trustees be empowered to expend sufficient funds to continue the work of the committee.

ON THE DELEGATES TO THE A. M. A.

The Reference Committee resolved that the Report of the Delegates to the A. M. A. is very satisfactory and recommend that the Delegates be commended for their work.

ON THE STATE BOARD OF MEDICAL EXAMINERS

Reference Committee "E" recommends that the report of the State Board of Medical Examiners be approved and the committee commended for the excellent work done.

ON THE SUB-COMMITTEE ON LEGISLATION

Study of the report of the Sub-Committee on Legislation justifies the conclusion that this committee has taken a broader and more detailed interest in legislation than has ever before been attempted by the State Society. Two important bills of positive advantage to the profession have become laws—S-136, the Physicians' Lien Act, and A-132, which legalizes school physicians to participate in the E. R. A.

Also certain other proposed Acts detrimental to the medical profession or to the general public were retarded by the influence of the committee.

The work of this Committee appears to us to be of outstanding benefit in at least three directions; first, in promoting legislation in the interest of physicians; second, in giving to individual legislators an understanding of the meaning and of the consequences of proposed health legislation; third, in concentrating the legislative influence of the profession in the interest of the general public.

We cannot too highly commend the work of this committee and especially approve of their plan of contacting the legislators through the "key men" of each component society.

PRESIDENT QUIGLEY: Dr. Hawkes, is it your thought to continue the Committee on the Physicians' Lien Act as long as it is necessary?

DR. HAWKES: We recommend that it be continued.

PRESIDENT QUIGLEY: The Report of Reference Committee E has been submitted. There are one or two things that should be discussed. Will someone make a motion that the report be adopted, so we can get it before the House?

DR. RICHARD M. A. DAVIS (Salem): I so move.

The motion was seconded.

PRESIDENT QUIGLEY: It has been regularly moved and seconded that the Report of Ref-

erence Committee E and the recommendations contained therein be adopted. Is there any discussion? Dr. Weigel, do you wish to say anything with regard to the recommendations with respect to the Special Committee on Physicians' Lien Law? Do the recommendations meet with your approval?

DR. WEIGEL: I only wish to add that, in so far as Dr. Hawkes' committee has advised, we try to contact the representatives of the Bar Association and the insurance carriers before this fee schedule is submitted to the various County Societies. I think we might in that simple manner obviate a great deal of trouble that otherwise would be brought out in the various counties; and we have at a meeting held here since Dr. Hawkes' committee reported, decided to get in contact with these various bodies and see if we can't get their support before it is transferred to the County Societies.

PRESIDENT QUIGLEY: Is there further discussion or any questions with respect to the committee report? Are you ready for the question?

The question was called for and the motion was put to a vote and was carried.

43. REPORT OF REFERENCE COMMITTEE F PUBLIC HEALTH Sect. 15.

MATERNAL WELFARE Sect. 16.

PRESIDENT QUIGLEY: Reference Committee F, Dr. Hollinshed, Chairman.

Dr. Hollinshed read the report of Reference Committee F, as follows:

REPORT OF REFERENCE COMMITTEE "F" PUBLIC HEALTH

Committee F is in accord with the work done by the Public Health Committee and is in favor of the recommendations of the committee except Recommendation No. 5 of the original report. This, we feel, should be changed to read "Funds *should* be provided in the State and County Society, etc."

Committee F in commenting on the report would stress the fact that they believe the relationship between physician and patient should be maintained.

Furthermore, that steps should be taken at once to create a greater interest in the County Societies, particularly in the rural sections.

We have purposely avoided discussion of recommendation No. 5 because we feel that this will eventually be worked out

We recommend that the work of the committee be continued and that the committee be commended for its work.

REFERENCE COMMITTEE F

Dr. Ralph K. Hollinshed,
Chairman

MATERNAL WELFARE

Committee F is in accord with the work done by the committee and approves the recommendations made.

Committee F feels that the State Committee on Maternal Welfare should take steps to increase the activities of the several County Committees.

Presuming that the State Committee is open for suggestions, Committee F recommends that the necessary steps be taken in order to secure a more accurate listing of the maternal deaths. For instance, the separation of deaths from medical causes, the deaths from septic abortion and the deaths from obstetrical cases proper.

The reason for this is obvious, for if it is done the maternal mortality statistics will be reduced materially.

It has also been suggested that the importance of prenatal care be particularly emphasized in the rural communities and the thickly congested districts.

Committee F also recommends that the State Committee have literature prepared which may be used by the County Committees in the local press to increase an interest in prenatal care.

Committee F recommends that the work of the State Committee be continued and that they be commended for the work already accomplished.

REFERENCE COMMITTEE F

Dr. Ralph K. Hollinshed,
Chairman

DR. RALPH K. HOLLINSHED: While I am on my feet, I should like to suggest to the House of Delegates, or the proper committee, that in future years proper accommodations be made for the use of Reference Committees, and that it be made possible for the posting of notices to be done as to the place of meeting so that members of the House of Delegates may be present and meet with these Reference Committees so that we may be able to present better reports. (Applause.)

PRESIDENT QUIGLEY: The Report of Reference Committee F on the matters referred to it is before you. What is your pleasure?

SECRETARY MORRISON: I move it be accepted and the recommendations concurred in.

The motion was regularly seconded and carried.

44. PROGRAM AND ARRANGEMENTS

Sects. 3, 40 and 43.

DR. ELIAS J. MARSH (Passaic): May I add that the last part be referred to the Committee on Program and Arrangements for next year?

PRESIDENT QUIGLEY: I think the maker of the motion will accept the suggestion as to the provisions for making the suitable accommodations for the meetings of the Reference Committees and an improvement in the method for announcing the time and place of these meetings, and so that that will be referred to the Committee on Program and Arrangements.

The motion was put to a vote and was carried.

45. AMENDMENT TO BY-LAWS REGARDING STANDING COMMITTEES

PRESIDENT QUIGLEY: Yesterday the Reference Committee on Constitution and By-Laws submitted a slight change to Chapter VIII of the By-Laws, which constituted a first reading. (Section 26.)

The second reading is as follows:

"Amend Chapter VIII, Section 2, to read as follows:

"The Standing Committees shall be: Nominating Committee, Committee on Finance, Scientific Work, Program and Arrangements, Publication, Honorary Members, Hospitals and Medical Education, Committee on Medical Defense, Committee on Insurance * * *

(and immediately under the listing of these committees, place these words:)

"* * * and such other committees as the House of Delegates shall determine."

Will someone move the adoption of this amendment?

DR. H. R. VAN NESS (Essex): I so move. The motion was seconded.

PRESIDENT QUIGLEY: The purpose of that is to give a little more latitude to the House of Delegates. If, as experience determines, it is decided that it is desirable to make some other committee a standing committee, as this section is now worded, it precludes such action.

The motion was put to a vote and was carried.

46. PRINTING THE CONSTITUTION AND BY-LAWS

DR. CHARLES J. MURN: The Committee on Constitution and By-Laws has one other suggestion and that is that the Constitution and

By-Laws has not been printed since 1929, and it is suggested that a new copy be printed and brought up to date, if the finances of the Society will so allow. I make that as a motion.

SECRETARY MORRISON: Will you add to that motion that they be published by the Publication Committee, or rather that they be distributed by the Publication Committee.

DR. MURN: Certainly.

The motion was regularly seconded.

PRESIDENT QUIGLEY: If you will permit me, I suggest that a limited number be made. I have in mind that it is quite possible with some suggestions that will be made, I understand under new business. Quite a change in the By-Laws may be necessary; therefore, it would be inadvisable to have a great many copies made. The idea, I take it, is to have sufficient of them to provide for the immediate needs of the Society, so that all those members will have the Constitution and By-Laws brought up to date. Is that your thought, Dr. Murn?

DR. MURN: Yes.

PRESIDENT QUIGLEY: It is regularly moved and seconded that the Committee on Publication be authorized to print and distribute a sufficient number of copies of the Constitution and By-Laws as amended to date.

The motion was put to a vote and was carried.

47. COUNCILOR DISTRICTS

PRESIDENT QUIGLEY: Are there any other Reference Committees to report? If not, we will proceed to unfinished business, or, if there is any new business, that may be taken up by unanimous consent. Do you wish to take up the matter of the redistricting? Are any of the Councilors present, do you know? Dr. Snedecor, I think, is still a Councilor.

DR. SNEDECOR: Do you wish me to take up for discussion the recommendation which the Judicial Council made to the Board of Trustees?

Jour. May, page 265; see also Sect. 13.

PRESIDENT QUIGLEY: Yes.

DR. SNEDECOR: The burden of work of the Judicial Council has been increasing during the past five years. Originally, as the name implied, it was a Council to act on questions of ethics, principally, and the work in that line was not very burdensome; however, the challenge for organization in this Society has been partly met by assigning new duties to these Councilors who could represent districts.

You have your State Society set-up, your County Societies—in between them the Judi-

cial districts stand out as an intermediate unit which could very profitably function in aiding organization along certain effective lines.

Under the present Act there are five Judicial Districts and five Councilors, giving four counties and four districts to four districts and five counties to one. Our experience in the past year particularly, where the Judicial Councilors have been assigned a good share of the organization work of the Emergency Relief Committee has shown that these districts are too large for close contacts. The Judicial Council sees that in the future development there is a greater place for supervisory work for a man in a district, for closer contact, for spreading the work of the State Society, and the present districts are in many ways a handicap for the Councilors to cover.

For instance, Camden District is now covered by the Councilor from Asbury Park, and it is a long way from Camden to Asbury. In my own district we have Hudson, Passaic and Bergen, and then jump through Morris County and take Sussex, and I might mention other such districts to you.

There doesn't seem to be a really better division on a basis of five districts, so at our last meeting the Judicial Council unanimously recommended to the Society that there be a redistricting of the Judicial Districts, that seven districts of three counties each would offer a much more efficient division and better units, with one man for three counties who could make closer contacts and carry out better work, and, as I am explaining it, the recommendation is that the Judicial Council be increased to seven and the districts be reallocated on a basis of three counties to a district.

PRESIDENT QUIGLEY: Do you make it as a motion?

DR. SNEDECOR: I shall be glad to make it as a motion.

The motion was regularly seconded.

PRESIDENT QUIGLEY: It is regularly moved and seconded that the number of Judicial Districts be increased from five to seven.

DR. ELIAS J. MARSH (Passaic): Since I saw this recommendation printed, I have given some thought to it; and I think there is very much in what Dr. Snedecor has said, but there is one thing, Dr. Snedecor, that I think is not embodied or emphasized in the motion, and that is that he emphasized the original judicial function of the Council as somewhat different from the executive function that has more recently been placed upon them, and I wondered in thinking this over, if it might not be a good idea to separate the two functions again; that is to say, it requires dif-

ferent types of mind and different types of men to be components of a good judicial body, court or judicial council, and to be the head executively of a group of counties, and I wonder whether it might not be a good idea to constitute a Judicial Council elected in a somewhat different way, possibly from the Fellows or, at any rate, among older men of judicial experience, and then to have seven, or as many as may be necessary, districts, executive districts, groups of counties which could elect their own chairmen among themselves, or a chairman could be elected here by the House of Delegates, and they could be put in charge of executive men, men of that type of leadership and mind, different from the type of mind required for the solution of the other difficulties, as Dr. Snedecor said, where there are no heavy, or onerous, or frequent judicial problems that come up.

That may be a better solution. I don't know whether it should be offered as an amendment or in what form it could be put, but that suggestion is for the House if they want to take any action on it or any consideration of it.

DR. MARCUS NEWCOMB (Burlington): I think this is an excellent idea, but I should like to ask Dr. Snedecor to add an amendment to his motion and refer this to the Board of Trustees to appoint a committee to redistrict the state. It may be it would be better to have one district of two of the large counties and another district consisting of three small counties, not arbitrarily having each district have three counties. I think a committee of the Trustees can work it out.

A number of changes have got to be made in the By-Laws at the same time. I offer that as an amendment, if Dr. Snedecor will accept it.

SECRETARY MORRISON: I should like to second that amendment inasmuch as this matter cannot be adopted at the present session of the House of Delegates. It implies an amendment to the Constitution and By-Laws, and it will have to go over until next year.

It is an excellent idea to put it in the hands of the Board of Trustees to study the redistricting. It will make a marked change in the representation on the Board of Trustees. We would have to have fourteen Trustees, or seven, and the terms of office of pre-elected Trustees would have to be rearranged.

DR. SNEDECOR: I should be glad to accept the amendment offered, particularly as it has been pointed out that no action can be taken at this time.

PRESIDENT QUIGLEY: While you are on

your feet, do you care to make any comment on the thought expressed by Dr. Marsh? As I interpret it, he feels that with the increase of the functions of the Councilors, acting as coordinators of their own Councilor Districts with the State Society, that perhaps calls for different type of individual from one who might be called upon to decide the questions of ethics. In other words, he thinks it requires a judicial type for one and an organizing type and a coördinator for the other.

This is a point of view that hasn't occurred to me and perhaps may not have occurred to many of us. Have you any thought on that?

DR. SNEDECOR: Mr. President, being the only Councilor present, I can give only my own views and I don't wish it to be inferred that I am giving the views of the other four members.

I might add some additional duties that have developed upon the Judicial Council. One of the previous duties was rather a general supervision of the lawsuits against physicians, and malpractice suits. This was largely dropped for a time, when our insurance contracts were made with U. S. F. & G. They took over most of that trouble, but when they began to raise the rates, and the number of malpractice suits were eased, it was thrown back in our laps to help reduce the number of suits, so there is another duty for the Council.

Then, again, it was urged upon us that we coördinate the societies and arrange for district meetings, group meeting. It seems to me that this whole subject had better be left open for further study by the Judicial Council for further recommendations in conjunction with the Board of Trustees, and be referred back at the beginning of the next session, next June.

PRESIDENT QUIGLEY: Do you withdraw your motion and substitute that?

DR. SNEDECOR: I shall be glad to.

DR. POLLAK: I second the substitute motion.

PRESIDENT QUIGLEY: It is regularly moved and seconded that the redistricting of the Councilor Districts and the question of functions, coördinating, or perhaps separating the duties, and the question of the recommended changes to the Constitution and By-Laws that will be necessary to effect this, be referred to the Trustees to be taken up in consultation with the Councilors, and a report be made thereon at the next Annual Meeting.

The motion was put to a vote and was carried.

48. COMMUNICATION TO THE AMERICAN MEDICAL ASSOCIATION, CONTINUING SECTION 38

PRESIDENT QUIGLEY: Is Reference Committee A ready to make a report on resolutions?

DR. POLLAK: Being fearful that the attendance of the House of Delegates might be depleted by a late return of the minority members of the Committee, we have drawn the following skeleton resolution, which we hope you will carefully dissect and then reconstruct, if you so desire, and adopt if it meets with your approval:

Whereas, The Medical Society of New Jersey, assembled at its 168th Annual Meeting at Atlantic City, New Jersey, through its House of Delegates has approved the recommendation contained in the Annual Address of the President, Dr. Frederic J. Quigley, relative to the crisis of organized medicine; and

Whereas, We appreciate that unless the parent body of organized medicine, the American Medical Association, immediately assumes the leadership to meet the greatest threat that has ever been made to American medicine, to wit, the menace of control of medicine by the state; be it

RESOLVED, That the delegates representing The Medical Society of New Jersey in the House of Delegates of the American Medical Association be directed to call attention to the House of Delegates to our concept concerning the imminent crisis now upon us; and be it further

RESOLVED, That our delegates be requested to use their best efforts to the end that a plan and scope to meet this emergency be forthwith promulgated through the channels of the American Medical Association.

I move its adoption.

Secretary Morrison seconded the motion.

PRESIDENT QUIGLEY: You have heard the resolutions recommended by Reference Committee A to the delegates of our Society, to be presented to the House of Delegates of the American Medical Association on June 11, 1934.

The motion was put to a vote and was carried.

PRESIDENT QUIGLEY: It is so ordered.
Is there further new business?

49. FEDERAL PURE FOOD AND DRUG ACT

DR. WATSON B. MORRIS: As President of the Union County Medical Society, I wish to read the following communication:

Mr. President and Delegates of the State Society: The Union County Medical Society wishes at this time to call the attention of the members of the

House of Delegates to a matter which we feel is very vital to the profession and the public at large.

It is the existing conditions in the Federal Pure Food and Drug Laws at the present time.

I am sure you are all familiar with the violations as they are repeating themselves and our Society felt the need of some action in this most vital subject so a Committee was appointed by our Society to investigate the Wiley Act of 1906, and the Copeland Bill, Senate Bill 2800, and the records of enforcement.

This Committee, after a thorough and intensive study of certain documents and other records, found ample proof of the fact that, where infringements of the Wiley Act had been proven, according to Court records, prosecutions were not carried out according to the law.

In the official report of the Food and Drug Office of the Department of Agriculture there were reported 2567 cases of proven violations in 1932.

The law orders all cases to be proceeded against by libeling and destroying the unfit articles, and criminal prosecution of the persons causing the offense.

The report states that all these cases were libeled, which was found to be true, and reports that 1307, or 50.9 per cent of these cases, were prosecuted. Investigation of the Court records and these actions reveals, however, that there were only 409 criminal actions, or about 10 per cent, and those offenders who were not prosecuted criminally have continued to safely violate the act.

One very important and serious violation has a very definite bearing on the high mortality rate in the field of obstetrics in the United States.

I am sure we are all aware of the inferior quality of Ergot as sold on the market at this time and the recent report of the National Committee appointed to study the subject rather bears out the contention that we need drastic measures such as could only be accomplished by intensive Congressional investigation; therefore, I would offer at this time the following resolution and ask for its adoption by our State Society:

"Whereas, the attention of some of the Component groups of the State Society have been informed of many irregularities in the investigation and prosecution of sale of impure drugs and foods which are a danger to the public health, we would recommend that the delegates to the meeting of the American Medical Association be instructed to bring it to the attention of the Association at its Annual Meeting urging Congressional investigation for the purpose of correcting these evils which are a danger and a menace to the public health.

"W. B. Morris, President."

PRESIDENT QUIGLEY: This is an important matter of new business and requires unanimous consent for its introduction. Is there any objection to its introduction?

There is a resolution in it, and I assume Dr. Morris moves its adoption.

DR. MORRIS: Yes.

The motion was seconded by Dr. Weigel.

PRESIDENT QUIGLEY: The resolution is as follows.

"Whereas, the attention of some of the Component groups of the State Society have been informed of many irregularities in the investigation and prosecution of sales of impure drugs and foods which are a danger to the public health, we would recommend that the delegates to the meeting of the American Medical Association be instructed to bring it to the attention of the Association at its Annual Meeting, urging Congressional investigation for the purpose of correcting these evils which are a danger and a menace to the public health."

There is one member of the House of Delegates present, whose opinion on this resolution I am sure would be of value, because he has first-hand knowledge of some of the impure drugs. I wonder if Dr. Ill wouldn't say a word on this.

DR. EDWARD J. ILL (Newark): The motion by the gentleman from Union County requesting the A. M. A. to propose an examination of the adulteration of drugs by Congress is well taken. My personal experience in the affair of adulteration of ergot was a hard one. I was told that the use of ergot was a matter of the past. The argument does not hold, since the importation of ergot has years ago amounted to 160,000 pounds, while last year it amounted to 400,000 pounds. The whole question turned on the question whether the two main sources of ergot, Russia and Spain, were equally good. While the Russian ergot sold for \$1.50 a pound, the Spanish ergot sold for \$2.50. The Russian ergot did not come up to the standard prescribed by the U. S. Pharmacopoeia, because it was not properly cared for. Otherwise it would have been just as good as the Spanish. The Association of the American Gynecologists and Obstetricians appointed a committee at my request to study the matter. Dr. John O. Polak, Dr. W. F. Dannreuther and myself as chairman were appointed. Of course I did all the work and was directed by the Association, because of its importance, to make an immediate report and not wait until the next meeting. I did so, after offering the paper and all the references, which made a large package, to the other members of the committee. I offered a copy to the editor of the A. M. A. for publication. This was refused and at my own expense I published the result of my work and mailed a copy to every member of the Association of American Gynecologists and Obstetricians. The efforts on my part to bring this matter of adulteration of ergot and the useless proprietary preparation failed because of the opposition of the Bureau

of Drugs and Foods. Two men of this bureau came to my office and threatened me with what was going to happen if I should go before the Senate Committee whose Chairman was Senator McNary. Nevertheless, I went. I spoke to this committee on the failure of the present-day ergot which I had found by personal experience.

The watery extracts which for years had been permitted by the Council of Pharmacy were known to be perfectly ineffective and were so conceded later by this Council. Because of my evidence as to the uselessness of the fluid extract of ergot unless its preparation was according to the direction of the American Pharmacopoeia, the editor of the A. M. A. Journal, page 727, September 6th, 1930, made this statement: "The report makes clear that Dr. Ill, honest and well meaning as he may be, is not particularly versed in the matter of weighing therapeutic evidence." At the meeting of the Association held about September 10th, 1930, at Niagara Falls the whole report was tabled. At this meeting there was a large representation of the Bureau of Drugs and Foods whose intention was to kill the report, and they did. If the A. M. A. had representatives, I do not know, as everybody seemed to shun me.

My whole report was made up from references which I had collected and to which Dr. Rusby offered his assistance. There was no reason why I should not ask for help.

My best argument, however, came from the report of Marvis R. Thompson, Assistant Pharmacologist, Pharmacological Laboratory of the Food, Drug, and Insecticide Administration. This report was presented to the scientific sections of the A. P. H. at its meeting in Rapid City, 1929. He is particular to let us know that the coxcomb methods of assay (bio-assay) are not reliable and cannot be relied on by the clinical results. By that method some specimens are rated at much less than one hundred per cent, while others will show three hundred per cent. The paper is well worth perusal. It is an honest understanding of the whole question of the pharmacology of ergot. Commercial interests were never mentioned in my paper. That was never in my mind. If you think that the A. M. A. is going to ask for a Congressional investigation of the adulteration of foods or drugs, or the Bureau, read the extensive bitter article on this question written by whom I do not know, under the caption of "Special Article" in the September 6th number, 1930, of the Journal. This was published one week before the annual meeting of the American Association of Gynecologists and Obstetricians.

cology and Obstetrics. If after that you can expect our "Mother Association" to take part in such work, you have more faith than I have. Senator Copeland's ending remark was "That it is a terrible thing to assist in any way in tearing down public confidence in any department of the government." We all know who Dr. Copeland is. This is typical of what one may expect. An ordinary citizen is asked simply to pay his taxes and not complain. The departments of the government are three times holy.

PRESIDENT QUIGLEY: As I said before, of course, as the presiding officer I am not supposed to enter debate, but I have some information with respect to this matter of pure foods and drugs which I should like to place before you.

There is a gentleman by the name of Mr. Ambruster who has been devoting a great part of his energies to attempting to correct some of the violations of the Pure Food and Drug Law and also attempting to have the Department of Agriculture, the Department which is charged with the enforcement, really take effective means to enforce the act.

The Tugwell, or Copeland-Tugwell, Pure Food and Drug Act, which the Public Health Committee endorsed, has been so emasculated, first by the Copeland Committee and then by the Committee on Interstate Commerce, I think that today it is practically worthless.

Mr. Ambruster has been contending that the old Wiley Act, if it were enforced, is a preferable act to the Tugwell Bill. In looking it over myself, the only advantage I saw in the Tugwell Bill was that it included cosmetics, which the Wiley Act did not, and I rather feel, with Dr. Ill, that if we are to get effective action, we would have to proceed in a different way, and the thought has just occurred to me that we have a Tri-State Conference which might consider the question. It has lapsed this year by reason of the fact that New York withdrew. We are attempting to get a set-up of the Tri-State Conference of a character which will make it likely for New York to reënter it.

Would it not be a worthwhile project for these three States, New York, New Jersey and Pennsylvania, to take some joint action and let these states make proper representation to the Congressmen and the Senators representing these states, and continue to press it? It would be an influential group, and I am wondering whether that would appeal to the maker of this motion and to Dr. Ill; and if it did, perhaps a motion of that sort could be made; and in addition to that, we could

ask the Welfare Committee to appoint a sub-committee to take up this matter immediately and after consideration make representations to our own Representatives in Congress and to our Senators to request this Congressional investigation.

I wonder how Dr. Morris and Dr. Ill feel about that.

DR. MORRIS: I think that is a very good suggestion. The only point that I had to make is that our Committee made a very thorough investigation and they really have something which is really constructive. Of course, it isn't possible, as Dr. Ill says, to get very far with it; but after our committee made this very thorough investigation and has very definite facts which it would be very glad to present to the delegates, we felt that it would be a good plan for our State Society to go on record as being in favor of some Congressional action.

I agree with Dr. Ill that we probably won't get very far, but it may be the beginning of something, and I think your suggestion of taking it up at the Tri-State Conference is very excellent. I shall be very glad to accept that.

PRESIDENT QUIGLEY: Would it be the thought to adopt this resolution; and then introduce another resolution that the matter be taken up directly by the Welfare Committee of this State Society for presentation to our own Legislators; also to be taken up by the Tri-State Conference, and attempt to further it as a group?

The motion has been made and seconded that our Delegates to the A. M. A. be instructed to ask the A. M. A. to ask for a Congressional investigation on the question of pure food and drugs. Is there further discussion on this?

DR. MARCUS W. NEWCOMB (Burlington): Mr. President: The President in his address pointed out that the American Medical Association hadn't done anything to prevent socialized medicine. Now, it seems to me that we are paying a lot of money to the officers of the American Medical Association to protect the interests of the medical profession of the United States, and what are we getting for it?

If we didn't get any more service out of the officers of the New Jersey State Medical Society than we are apparently getting out of the American Medical Association, we would fire them out pretty quickly, which we ought to do.

It seems to me we should instruct our Dele-

gates to the American Medical Association next week that the New Jersey State Medical Society is not satisfied with the service that they are giving the medical profession of the United States, and that we serve notice on them that they must wake up and be alive to the conditions that are facing the medical profession in the United States, or that we, as one of the forty-eight States, will start proceedings, or propaganda, or publicity, whatever you want, to put somebody in Dr. Fishbein's place and Dr. West's place who is alive and working for the interests of the medical profession.

I make that as a motion, that that be added to the instructions of our Delegates, and I know Dr. Pollak can get up there and talk and he ought to get up in that House of Delegates and tell them just what he thinks of them. (Applause.)

PRESIDENT QUIGLEY: Unfortunately, Dr. Pollak is no longer a delegate to the American Medical Association.

DR. FRANK W. PINNEO (Essex): In transmitting the action of the Essex County on the subject which Dr. Ill has so ably and intelligently and with experience, discussed, Essex County, instead of discussing it before the Council or in Essex County, has transmitted a resolution on the action of this Society through the Welfare Committee, hoping for action.

This supplementary remark of Dr. Newcomb on this subject is apt and clinches the thing, hits it right on the head. Let us do something, and if this goes straight to the A. M. A. next week, as strong as possible, from New Jersey, even without Pennsylvania and New York, it will be accomplishing something.

DR. WEIGEL (Union): The investigation which we made in Union County in reference to this evidence that was submitted to our Society carried it way beyond the question of just the matter of pure ergot. One of the most glaring things, the thing that seemed probably one of the greatest illustrations of violation to us, was the fact that there was a tremendous amount of ether that apparently was in the hands of the Government after the war and declared unfit for anesthetic purposes. This ether was sold to an individual who gave a bond that it was to be used for other purposes than anesthesia; and when he found the Government was not spending money to enforce the Pure Food and Drug Act, he turned around and sold the ether for anesthetic purposes, and the records show quite a few deaths followed the use of that ether.

It seems to me it is a pity when a considerable part of the Medical Society of our State is convinced that these irregularities exist, that we should be absolutely bound and are unable to get a hearing where it will do some good.

I do not know enough about the politics of the A. M. A. to know how it has to be greased to get in there, but I feel as though, when as representative a body as our State Society takes some positive action such as Dr. Newcomb just suggested, somebody should be made to listen to us. I don't like to feel that we have got to sit here and say nothing can be done. (Applause.)

DR. JOSEPH MARK (Middlesex): Mr. President, in connection with this matter I wish to state that Mr. Ambruster appeared before one of the meetings of the Middlesex County Medical Society, in which he related at great length the violations that he thought were present in the non-enforcement of the provisions of the old Wiley Act. As a result of his opinion, the matter was referred to our Public Health Committee, who empowered our Delegates at the present time to submit a resolution to the effect that the entire matter of the non-enforcement of the Wiley Act be referred to the Welfare Committee of the State Society for its thorough study and action.

Furthermore, if it were found advisable to move or second the enactment of the Tugwell-Copeland Bill, there should be incorporated within that Bill mandatory provisions for punishment of violations of the same, which we understand at the present time do not exist in that proposed Bill.

At the same time I wish to call your attention to the fact that Mr. Ambruster has printed copies of his address, which he is, I understand, circularizing among members of the medical profession, with the preface that the same was delivered before the Medical Society of Middlesex County.

PRESIDENT QUIGLEY: Is there further discussion on this very important subject?

DR. B. S. POLLAK: Mr. President, supplementing the remarks of Dr. Ill, for whose judgment and opinion all of us have the greatest respect, I, nevertheless, speaking on behalf of the Delegates of the American Medical Association from this State, who are not here today, want to say that none of them is looking for public office or public preferment in the ranks of the American Medical Association and thier voices will be heard, and it will not be a voice crying in the wilderness.

Let us not forget, gentlemen, that the delegates to the American Medical Association, representing forty-eight states of this Union,

are represented by the type of gentlemen such as we send from New Jersey into the American Medical Association, men imbued with high ideals, men conscious of their obligation, and it is merely because some of these gentlemen are not on their feet in order to give expression, that many of these problems are not heard.

I want to cite to you an incident that happened last year, in order to convince you that matters can be introduced in spite of well-organized machinery, such as even we have. (Laughter.) That is this: The Committee on Public Health of New Jersey presented last year a very voluminous document concerning the future activity of the Public Health and Sanitation. President Quigley forwarded that report to me, subsequently to the time that resolutions could be introduced. Resolutions concerning new business must be introduced on the first day of the session, which is on Monday; then the House of Delegates meets again on Tuesday. It does not meet on Wednesday, but meets in Executive Session on Thursday. At that time, the report having come later, I was unable to present it either on Monday or on Tuesday, but by reason of recognition by the Speaker of the House, I had the privilege to rise on the question and submit this problem. A special committee was appointed to investigate it. They reported back upon the measure, complimenting New Jersey, and particularly the Committee on Public Health.

So I think, gentlemen, before we adopt any resolution so drastic in scope and effect as the resolution which has been offered by my distinguished colleague from Burlington County, that we ought to be more cautious concerning its effect relative to other things that we have in the wood. These are peculiar days and it is entirely likely and possible that heeding the call which comes to the American Medical Association in the preamble which you have just adopted, there is a possibility that their ears may be to the ground and that they may be listening to the reactions which are coming not only from New Jersey but also from various other States of the Union, that are quite alive and quite alert to the status of American medicine at this time.

I think that it might be well to hold this motion in abeyance and not send a threat, which this is, a threat, to the American Medical Association at the critical juncture of our existence. (Applause.)

DR. NEWCOMB: According to Dr. Pollak, the Delegates have high ideals and I think they

have all of them. They have not left any for the officers of the American Medical Association, perhaps, and I think that we should send our resolutions just as strong as we can put them.

Now, Dr. Fishbein is a fine talker to go all over the United States and talk, but what is he doing? I think we have plenty of other evidence that they aren't on the job and that they want stirring up, and they want stirring up good and proper, and I ask for a vote on my resolution.

DR. STANLEY H. NICHOLS (Monmouth County): I should like to endorse Dr. Newcomb's statement to the effect that the American Medical Association needs stirring up. A lot of us have wondered for a number of years past what was the matter with the American Medical Association. All of us have seen Dr. Morrison's comments in Chicago and elsewhere on the story that we should be ready for sickness insurance; also his statements that, in any country abroad where sickness insurance has been put into effect, it has resulted in a lower quality of medical service to the public, and that is a well-known fact in this country and abroad today.

I think that probably a composition of the two feelings, of Dr. Newcomb and Dr. Pollak, perhaps is in order. I think the A. M. A. has plenty of funds. They recognize that the American medical group is very loosely organized. When we tried to get the doctors to defend their rights three or four years ago in the State Society, we were afraid the County Societies wouldn't string along with the State Society. I think today that fear is dissipated, that the State Society, under Dr. Quigley's leadership, is well organized, and we are taking care of ourselves.

We have had so far in the American Medical Association a wonderful house with plenty of money and the grandest set of bureaus in that house that there has ever been in any house that was furnished with bureaus, but perhaps the superintendents of the house—and they have great ability, as Dr. Pollak has said—are waiting for a suggestion from these State Societies that if they will assume real leadership, we are willing to go along with them as State Societies and follow that leadership.

I really believe that the American Medical Association is ready to act, and we will not be the only State Society to come out there this year. Michigan and several other State Societies are coming with the same message; and if we say to them, "You have the ability and the bureaus and the knowledge; you set

up defense on the sickness insurance, and make a real, coherent businesslike organization out of the A. M. A., such as we are attempting to do with the State Society," then they will respond to the request, I think. I think that is what they mean when they say they want it to come from the States.

I think we should say it perhaps politely rather than otherwise, that we want them to do business.

PRESIDENT QUIGLEY: Is there any further discussion?

DR. CHESTER I. ULMER (Gloucester): Mr. President and Members of the House of Delegates: I am quite conscious that I lack the legislative ability of Dr. Newcomb and the oratorical talent of Dr. Pollak, but I do believe I possess a very small amount probably of common sense. I don't think that a threatening attitude or a vindictive gesture at our parent organization, the A. M. A., is advisable.

I think there is a splendid compromising position. I don't think we will obtain much by a spirit of vindictiveness such as the motion made by Dr. Newcomb would reveal. I think that a lot of the criticism directed to Dr. Morris Fishbein is unwarranted. I think today he is probably the most brilliant, outstanding medical writer that the largest medical organization of the world possesses, and he has defended the pure food laws probably to a degree that he has not been complimented for. I have heard him in many addresses, and he has been a militant, spirited fighter. He has received many threatening letters and even missiles; and I think, gentlemen, that it would be unwise for this body, and certainly unprofitable, to direct through its Delegates a resolution so scurrilous, so violent, as the one proposed by our colleague.

I am in favor of a resolution, but not one so written. Let it be compromised; let it be joined by others from Michigan and other States. I think it would be more productive.

I shall regret it very much, gentlemen, if we decide to accept the resolution offered by Dr. Newcomb, in as violently drawn up state as it is. Please consider it carefully. (Applause.)

SECRETARY MORRISON: Mr. President, I think there is a close similarity between Dr. Newcomb and myself. We always have our finger on the trigger and some revolvers are very sensitive. I believe the A. M. A. has its ear to the ground more acutely this year than ever before since it was organized.

California, Michigan, New Jersey, and some of the other states are after the A. M. A. on

a policy that they are carrying out in protecting the interests of organized medicine.

I am heartily in sympathy with the spirit behind this resolution of Dr. Morris and all the discussion, but I am going to suggest that Dr. Newcomb withdraw his motion and that he and Dr. Pollak retire for five or ten minutes and bring in a resolution that we will all feel more kindly toward adopting. (Applause.)

DR. FRANK W. PINNEO (Essex): It seems to us we are on a subject in which we are looking for action, in any organization like the A. M. A. If improvement, reform, increased service is to come, it must come from the constituent members. We all read in the papers of attacks on the American Medical Association, with which we are not in sympathy, from outside, disinterested sources. We are a constituent body, and if any improvement is desired from its service, let it come from the inside.

Dr. Newcomb is expressing a spirit and not phrasing a resolution, and as this action before us is to be submitted to our officers and Committee, they will frame it up properly. We want an expression of this House that we are in favor of radical action for practical results such as Dr. Ill has shown us we need. (Applause.)

DR. NEWCOMB: I am glad to withdraw my most drastic motion, as Dr. Ulmer calls it, but I might suggest to Dr. Ulmer when he is dealing with politicians in medical or any other kind of politics, don't be afraid to mince matters; tell them just what you mean, and mean just what you say. (Applause.)

PRESIDENT QUIGLEY: The question now is on the adoption of the motion proposed by Dr. Morris. Inasmuch as there has been so much discussion, it, perhaps, may have been forgotten. I will repeat it:

"Whereas, the attention of some of the Component groups of the State Society have been informed of many irregularities in the investigation and prosecution of sales of impure drugs and foods which are a danger to the public health, we would recommend that the Delegates to the meeting of the American Medical Association be instructed to bring it to the attention of the Association at its Annual Meeting, urging Congressional investigation for the purpose of correcting these evils which are a danger and a menace to the public health."

Are you ready for the question?

The question was called for and the motion to adopt the resolution was put to a vote and was carried.

PRESIDENT QUIGLEY: It is so ordered.

SECRETARY MORRISON: Now, may I suggest that Dr. Morris's motion and the discus-

sion that has taken place upon it be transcribed prior to the publication of our transactions and handed to the Chairman of our Delegation to the American Medical Association, Dr. Haggerty, prior to his departure for Cleveland to attend the session?

DR. MORRIS: I second that motion.

PRESIDENT QUIGLEY: It has been regularly moved and seconded that the motion adopted and the attendant discussion be transcribed promptly and given to the Chairman of our Delegation, Dr. Haggerty, so he will have it in his possession before leaving for Cleveland to represent this Society.

The motion was put to a vote and was carried.

DR. NEWCOMB: Doesn't that carry any instructions with it?

PRESIDENT QUIGLEY: They are right here.

DR. NEWCOMB: I mean to the American Medical Association.

PRESIDENT QUIGLEY: That was on the adoption of this.

DR. NEWCOMB: Then you are not taking action on this.

PRESIDENT QUIGLEY: We are. We are asking that the American Medical Association ask for a Congressional investigation. This is Dr. Morris's motion which was before the House. We were discussing that.

50. TRI-STATE CONFERENCE

DR. H. W. NAFEY: Did we do anything about referring this to our Tri-State Conference? Is that dropped?

PRESIDENT QUIGLEY: No, that hasn't been done.

DR. NAFEY: I should like to make a motion that this matter be brought before the reconstructed Tri-State Conference at its first session to be held this year.

DR. ULMER: I second the motion.

PRESIDENT QUIGLEY: It has been regularly moved and seconded that in the event the Tri-State Conference is recreated, this matter of the question of impure food and drugs and lack of enforcement be considered by the Tri-State Conference at its first meeting, and it is requested that our own representatives to this Tri-State Conference endeavor to secure concerted action on its part that will remedy the situation.

The motion was put to a vote and was carried.

51. PER CAPITA DUES

PRESIDENT QUIGLEY: I should like to call on Dr. North, Chairman of the Finance Committee, for the recommendations of the com-

mittee as to the dues to be levied and the per capita tax this year.

PRESIDENT QUIGLEY: Dr. North!

DR. NORTH: When I gave my report the other day, I showed the total expense of the Society would be something like \$44,000. (Sections 11 and 39; also Sect. 28.) Granting we have 2700 members, that would be something over \$16 per capita, but I told you we had something over \$5000 excess this year. That would account for \$2 per member, so even at that, the assessment should be \$14, but I recommended \$13 because I felt that with very strict economy we probably could get through with \$13, and, if we don't, we have a little money in the Treasury which I think we can get by with; so I will recommend that \$13 be the per capita assessment this year. I so move.

The motion was regularly seconded, was put to a vote, and was carried. (See Sect. 28.)

PRESIDENT QUIGLEY: Is there any other new business?

52. MEDICAL HISTORY OF NEW JERSEY

DR. W. B. MOUNT (Essex): I should like to make a motion in order to bring something up for discussion. I move that a committee of this Society be appointed to look into the Medical History of New Jersey, which would be about ready for publication now. I think I need to say no more about it unless questions are asked.

PRESIDENT QUIGLEY: I take it, Dr. Mount, you are referring to the Medical History which has been compiled by a group for which private subscriptions were raised.

DR. MOUNT: That is true. There is some money that has been expended already by individuals, but we should like to have a committee of the State Society look into the matter.

PRESIDENT QUIGLEY: With what purpose in view?

DR. MOUNT: The purpose of reporting what they think of the history.

PRESIDENT QUIGLEY: With the idea of publication?

DR. MOUNT: With the idea of publication, naturally.

SECRETARY MORRISON: I should like to amplify that a little. I am a member of the committee of three who have prepared this history and I think we prepared a very excellent work. It will be a volume of about 500 pages. It deals with the history of medicine from the time of the Indians up to the close of the Nineteenth Century. It is quite voluminous. It is a delightfully written, instructive work that I think every doctor in the state would be proud to have in his library.

When we asked for subscriptions in our original plan to put it over, we were promised subscriptions enough to have the work written up by our compiler and have it published, but the depression came and three or four thousand dollars of the pledges were never paid.

The work is finished. We still owe the person who compiled it a considerable sum of money, and we have offered it to certain publishing houses for terms and these publishing houses feel that if they could be assured of sixteen or eighteen hundred copies selling, they would go ahead and advertise it to the profession and have it published and give us a certain return on all the numbers that were sold over the sixteen hundred, with which we could defray our expense.

Dr. Mount's proposition is that the House of Delegates consider it and appoint a committee to confer with the History Club as to what is the best means of putting the book on the market.

PRESIDENT QUIGLEY: Dr. Mount moves that a committee be appointed to consider the question of publication of the Medical History of the State of New Jersey, this committee to report at the next Annual Meeting. Is this motion seconded?

The motion was regularly seconded.

DR. W. A. SWEENEY (Hudson): I should like to ask about this. This is not a matter for private endeavor, is it? Is the State Society committed in any way?

SECRETARY MORRISON: Just to report.

DR. E. S. CORSON (Cumberland): I am not aware that I have ever been solicited to subscribe for the history. I should like to know how many in the audience have been solicited to subscribe for it. I don't know that I have been personally solicited to subscribe for it.

SECRETARY MORRISON: I wish I had known at the time.

PRESIDENT QUIGLEY: How many do you want on the committee?

DR. NEWCOMB: Why couldn't the committee send out a questionnaire to every member in the State of New Jersey?

PRESIDENT QUIGLEY: I think that is, of course, embraced in the thought, and that is probably the reason for the appointment of a committee.

The motion was put to a vote and was carried.

53. PLACE OF THE 1935 ANNUAL MEETING

PRESIDENT QUIGLEY: Is there any other new business.

It is the function of the House of Delegates to decide upon the place of meeting for the

next Annual Meeting and also the approximate time, that is, what month.

SECRETARY MORRISON: The time is set by the Trustees.

PRESIDENT QUIGLEY: Will someone make a motion as to where the Society desires to hold the next Annual Meeting?

DR. NEWCOMB (Burlington): I don't believe we can get any better accommodations or any place more convenient than Haddon Hall. Our meeting room and committee rooms and everything else are all on one floor, and it is very pleasant. I move that we meet in Haddon Hall, Atlantic City.

The motion was seconded by Dr. Allman, was put to a vote, and was carried.

54. RESOLUTION OF THANKS

PRESIDENT QUIGLEY: Is there any further new business? If not, I think a motion to thank the Program and Arrangements Committee, the Ladies' Auxiliary, particularly the Committee on Entertainment, and the management of the hotel for the excellent assistance given in the conduct of this meeting, would be in order.

SECRETARY MORRISON: I so move.

The motion was regularly seconded, was put to a vote, and was carried.

55. THE EVENING SESSION ON PNEUMONIA

PRESIDENT QUIGLEY: Before entertaining the motion to adjourn, I trust all the members now here will stay for the evening session. It is always difficult to arrange the program to hold people over for the last session. The House of Delegates usually held its final session on the morning of the last day, and last year the first half-day was cut out by reason of the fact that the meeting started in the afternoon. That was half a day cut off. This year it was further contracted by reason of the fact that we are holding our last meeting on the evening of the third day, so that in the past two years we have cut down the actual time of the convention a full day.

The House of Delegates was put on the program for this afternoon's meeting because it was felt that the questions now confronting the profession are of such moment that the meeting of the House of Delegates should have preference over that of the Scientific Session.

We have arranged a fine symposium on pneumonia, with the first speaker Dr. Lewellys Barker, of Baltimore, and some of our own outstanding men to participate, and I trust you will be able to stay and make it possible to have a good meeting. (The attendance was 100, Jour., June, 1934, page 354.)

56. REPORT OF AUDITING COMMITTEE

DR. NORTH: How about the Auditing Committee? Have they reported?

PRESIDENT QUIGLEY: Are they ready to report, Dr. Nafey?

DR. NAFEY: The Auditing Committee appointed by the Chairman of the Board of Trustees, Dr. Eagleton, consisting of Dr. Herrman and I, have the following report to make:

Dr. Nafey read the Report of the Auditing Committee, as follows:

REPORT OF THE AUDITING COMMITTEE

Dr. Nafey and Dr. Herman

We have examined and checked the books, vouchers, cancelled checks and other papers furnished to us by Dr. J. Bennett Morrison for the Treasurer, Dr. Elias J. Marsh, and we find all such records correct and in order.

(Signed) Herbert W. Nafey,
W. G. Herrman.

Dated June 7, 1934.

PRESIDENT QUIGLEY: You have heard the Report of the Auditing Committee. What is your pleasure?

DR. ALLMAN (Atlantic): I move it be adopted.

The motion was regularly seconded, was put to a vote, and was carried.

57. INAUGURAL ADDRESS OF THE INCOMING PRESIDENT, DR. LANCELOT ELY

PRESIDENT QUIGLEY: We have a new departure this year. We have as one of the offi-

cers of the Society a President-Elect, and certainly I think it is of equal and perhaps more importance to know what the incoming President has to say with respect to policies and program than to know what the outgoing President has to say, and I should like to present Dr. Ely. Our relations have been most pleasant. Dr. Ely has given me the finest kind of support and coöperation, and I sincerely feel that the Society is going to have a good President this coming year with Dr. Ely in office.

My hope is that he may receive from all the officers and from the committees and the Component Societies the same fine support that has been given to me this year; and, if it is given, I prophesy that we will have under his leadership a most successful year. It is my privilege to introduce President-Elect Ely who will deliver his inaugural address.

The members arose and applauded.

President-Elect Ely read his address, which is printed on page 327 of the June Journal.

58. ADJOURNMENT

Upon motion regularly made and seconded, it was voted to adjourn. The 168th Annual Meeting of the House of Delegates adjourned at four-forty o'clock.

(Signed) FREDERIC J. QUIGLEY
President

(Signed) J. B. MORRISON
Secretary

SCIENTIFIC SESSIONS

The Scientific Sessions of the 168th Annual Meeting of The Medical Society of New Jersey were conducted in five general assemblies of the entire Society; and in seven meetings of the four scientific sections of the Society.

GENERAL MEETINGS

The first general meeting was held on the evening of Tuesday, June 5, 1934, and was on the subject of "Medical Economics". The speakers were as follows:

West Coast Experiments in Providing Medical Service

Seth A. Brumm, M.D., Philadelphia, Pa., President-Elect, Philadelphia County Medical Society

The Philosophy of Medical Service and Its Present-Day Applications

Frederick Elliott, M.D., Brooklyn, N. Y., Chairman Committee on Medical Economics of the Medical Society of the State of New York
Medical Practice Problems in New Jersey
Thomas K. Lewis, M.D., Camden, Chairman Subcommittee on Medical Practice of the Welfare Committee of the Medical Society of New Jersey
General Discussion; Leader, Edward W. Sprague, M.D., Newark

The second general meeting was held at noon on Wednesday, June 6, 1934, for the purpose of receiving the annual Presidential address by Dr. Frederic J. Quigley, President of The Medical Society of New Jersey, which was printed in The Journal of June, 1934, page 320. The address contained recommendations which were considered by the House of Delegates as described in sections 37, 38 and 48 of the Transactions.

The third general meeting was held on Wed-

nesday afternoon, June 6, 1934, at 2:30 p. m., with a scientific program as follows:

Allergic Diseases

Robert A. Cooke, M.D., Special Consultant, Allergic Clinic, Roosevelt Hospital, New York City

Discussors: George P. Meyer, M.D., Camden; Dean Marquis, M.D., Orange

Arthritis Considered as a Systemic Disease

Reginald Burbank, M.D., Chief of Arthritic Clinic, French Hospital, New York City

Illustrated with lantern slides

Discussors: John W. Gray, M.D., Newark; B. Franklin Buzby, M.D., Camden

Sub-Total versus Total Hysterectomy

Max Danzis, M.D., Newark

Illustrated with lantern slides

Discussors: William J. Carrington, M.D., Atlantic City; E. Zeh Hawkes, M.D., Newark; Edgar A. Ill, M.D., Newark

Prenatal Care in Relation to Maternal and Infant Mortality

Robert L. DeNormandie, M.D., Boston, Mass., Instructor in Obstetrics, Medical School of Harvard University

Discussors: Samuel A. Cosgrove, M.D., Jersey City; Norman J. Quinn, M.D., Atlantic City

Conference of County Maternal Welfare Committees

The fourth general meeting was listed on the program as an informal luncheon of the Woman's Auxiliary, during which Dr. Julius Levy, of Newark, described the "Pre-School Age Physical Status Survey of Children in New Jersey", made by unemployed nurses as a Federal project, with the object of determining the proportions of those who had been immunized against diphtheria and other infectious diseases.

The fifth general meeting was held on the evening of Thursday, June 7, its program being "A Symposium on Pneumonia", as follows:

Pneumonia

Lewellys F. Barker, M.D., Baltimore, Maryland, Prof. Emeritus of Medicine, School of Medicine, Johns Hopkins University

Pathology of Pneumonia

Harrison Martland, M.D., Newark

Pneumonia in Childhood

Walter B. Stewart, M.D., Atlantic City

Discussors: Arthur Stern, M.D., Elizabeth; Arthur M. Dannenberg, M.D., Philadelphia, Pa.

X-Ray Diagnosis

Joseph E. Roberts, M.D., Camden

Discussors: George S. Reitter, M.D., East Orange; J. B. Edwards, M.D., Englewood

Surgical Aspects

Richard H. Dieffenbach, M.D., Newark

Illustrated with lantern slides

This was the closing event of the Annual Meeting and was attended by one hundred members.

SECTION OF EYE, EAR, NOSE, AND THROAT

The Section on Eye, Ear, Nose and Throat held two meetings both in Haddon Hall, with the Chairman, Dr. S. T. Hubbard, of Hackensack, presiding, and Dr. George S. Laird, of Westfield, Secretary. The first meeting was held on Wednesday, at 9 a. m. and the second on Thursday at the same hour.

The program was carried out as announced on the printed schedule, as follows.

Wednesday

Diseases of the External Ear

Charles N. Dezer, M.D., Hackensack

Discussor: E. M. Tennis, M.D., Englewood

The Surgical Anatomy of Neck Infections of Dental Origin

Joseph A. Miller, M.D., South Orange

Discussor: Henry C. Barkhorn, M.D., Newark

Pathways of Intracranial Infection from the Ear, Nose, and Throat, with Diagnosis and Treatment

Henry C. Barkhorn, M.D., Newark

Discussor: Earl LeRoy Wood, M.D., Newark

Meningitis from Petrous Apex Infection

Wells P. Eagleton, M.D., Newark

Discussor: W. R. Tymeson, M.D., Orange

Sinusitis in Children

Lyman Richards, M.D., Surgeon in Otolaryngology to the Children's Hospital, Boston, Mass.

Discussor: James A. Fisher, M.D., Asbury Park

Thursday

Diagnostic Value of Optic Neuritis and Choked Disc in Nervous and Mental Diseases

Arcangelo Liva, M.D., Hackensack

Discussor: C. C. Beling, M.D., Newark

Some Practical Observations Concerning Ophthalmic Lenses

A. Russell Sherman, M.D., Newark

Discussor: J. S. Shipman, Camden

Uveitis

R. W. Baeseman, M.D., Asbury Park

Discussor: W. G. Mengel, M.D., Camden

Report of the Dr. Kipp Memorial Committee

Keratoplasty

Illustrated with moving pictures and lantern slides

Ramon Castroviejo, M.D., Research Fellow, Institute of Ophthalmology, Columbia-Presbyterian Medical Center, New York City

Discussor: E. S. Sherman, M.D., Newark

Report of Eye, Ear, Nose and Throat Section Nominating Committee

There was a discussion regarding the establishment of a Dr. Charles J. Kipp memorial fund which was proposed by Dr. Elias J. Marsh at the Section last year (see Transactions 1933, page 59). Dr. Kipp had practiced ophthalmology in Newark for over 40 years up to the time of his death on January 13, 1911, aged 78 years, and had served as President of the State Society in 1886. (See this Journal, February 1911, page 486.)

The following resolution was adopted:

Resolved, that the Eye, Ear and Throat Section proceed to establish a fund to be known as the Charles J. Kipp Memorial Fund, and to be used under the direction of the Section for the encouragement and assistance of original scientific or public health work in ophthalmology or otology in New Jersey.

Resolved, that the House of Delegates be requested to approve this action.

Resolved, that all moneys belonging to the Fund be placed in the custody of the Treasurer of the Society (the Board of Trustees consenting), to be held by him as a separate fund, and to be paid out only on authorization of the Section, as attested by the signatures of its Chairman or Vice-Chairman and its Secretary.

The Chairman of the Nominating Committee, Dr. Charles H. Schlichter, reported that the following officers were nominated by the Committee:

Chairman, Dr. James A. Fisher, Asbury Park.

Secretary, Dr. William K. Campbell, Long Branch.

These nominees were unanimously elected officers of the Section for the year 1934-1935.

S. T. HUBBARD, *President*

GEORGE S. LAIRD, *Secretary*

SECTION ON PEDIATRICS

The Section on Pediatrics held two sessions, with Dr. Walter B. Stewart, of Atlantic City, Chairman.

The first session was held on Wednesday, June 6, 1934, at 9:30, when the following program was carried out:

The Treatment of Erysipelas in Children
Kenneth Blanchard, M.D., East Orange
Discussor: H. O. Bell, M.D., Belleville

SYMPOSIUM ON DISEASES OF BLOOD

Hemorrhagic Blood Dyscrasias — Diagnosis and Treatment

Hyman I. Goldstein, M.D., Camden

The Clinical Control of Chronic Hemorrhagic States in Infancy and Childhood

I. Newton Kugelmass, M.D., New York City, Pediatrician to Fifth Avenue Hospital, New York City

Erythroblastosis in the New Born

Robert R. White, M.D., East Orange

The Diagnosis of Anemia

Russell L. Haden, M.D., Cleveland, Ohio, Physician to the Cleveland Clinic

Symposium Discussors:

N. Rosenthal, M.D., New York City

Matthew S. Ersner, M.D., Philadelphia

Robert A. Kilduffe, M.D., Atlantic City

The second session was held on Thursday, beginning at 10 a. m., jointly with the Section on School Physicians, according to the following program:

The Prevention of Acne Vulgaris in Adolescent Children

Stanley H. Nichols, M.D., Asbury Park

Discussor: Irving Okin, M.D., Passaic

Adult Pulmonary Tuberculosis in Children with Treatment by Compression Therapy

Samuel B. English, M.D., Glen Gardner, and

Max Gross, M.D., Glen Gardner

Discussors: John Runnells, M.D., Scotch Plains;

Stanley H. Nichols, M.D., Asbury Park

Contagiousness of Acute Respiratory Infections in Children from the Rhinologist's Standpoint

William John Greenfield, M.D., Hackensack

Discussors: Kenneth Blanchard, M.D., East Orange; Lewis W. Brown, M.D., Newark

Evaluation of the Various Procedures of Diphtheria Immunization

H. Louis Fuerstman, M.D., Newark

Discussor: Harry B. Silver, M.D., Newark

A Discussion of Current Problems in School Health Work

Allen G. Ireland, M.D., Trenton

A memorial was presented on Dr. Frank Chambliss Johnson of New Brunswick, who was Chairman of the Section during the 1933 meeting. Dr. Johnson died from the effects of a fall from a cliff in the Watchung Mountains, on January 1, 1934, while he was following his avocation as geologist. (See The Journal, February 1934, page 124.)

The following Section officers were chosen for 1934-1935:

Chairman, Frederic M. Lathrop, Plainfield.
Secretary, F. I. Krauss, Chatham.

WALTER B. STEWART,
Chairman.

SECTION ON RADIOLOGY

The Section on Radiology held meetings on Wednesday and Thursday, at 9 a. m. in Had- don Hall, with Dr. George S. Reitter, Chairman, and Dr. William G. Herman, Secretary.

The meetings were conducted according to the published program, as follows:

Wednesday

Suppurative Hip in Children

G. Herbert Taylor, M.D., East Orange, N. J.

Discussor: Harold Smith, M.D., Orange, N. J.

Protracted External Radiation in the Treatment of Neoplasms of the Upper Respiratory Tract

Milton Friedman, M.D., Newark, N. J.

Discussor: Elwood Downes, Woodbury, N. J.

Report of a Case of Foreign Body in the Esophagus

Erwin Reissman, M.D., Newark, N. J.

Lung Changes Subsequent to Irradiation in Breast Cancer

Elwood Downes, M.D., Woodbury, N. J.

Intrathoracic Anatomy from the Roentgenologist's Standpoint

Wm. Wallace Maver, M.D., Jersey City, N. J.

Why Gastric Cancers Show Characteristic Roentgen Findings

Lewis G. Cole, M.D., New York City

Thursday

Osteogenic Tumors

John Tidaback, M.D., Summit, N. J., and A. F. Galasso, M.D., Morristown, N. J.

Discussor: F. H. Pinckney, Morristown, N. J.

The Problem of Silicosis—A Practical Viewpoint

Raphael Pomeranz, M.D., Newark, N. J.

Roentgen Diagnosis of Lesions of the Esophagus

Chas. F. Baker, M.D., Newark, N. J.

W. Jas. Marquis, Newark, N. J.

Report of a Case of Mediterranean or Sick Cell Anemia

Austin Vogel, M.D., Elizabeth, N. J.

The Recognition of Some Forms of Intracranial Pathology

Chas. W. Schwartz, M.D., New York City Neurological Institute

Officers of the Section for the year 1934-1935 were elected as follows:

Chairman, Elwood E. Downs, Woodbury.

Secretary, P. S. Avery, New Brunswick.

SECTION ON SCHOOL PHYSICIANS

A meeting of the Section on School Physicians was held at 9:30 a. m. in the Hotel Chalfonte. The program consisted of a symposium on "Medical Economics as Related to the Public Schools", conducted by Dr. Allen G. Ireland, Chairman of the Section. Dr. Ireland presented his findings on the salaries of school physicians, to which those present added comments and criticisms.

A session of the Section on School Physicians was held jointly with the Section on Pediatrics in Haddon Hall, on the morning of Thursday, June 7, beginning at 10 o'clock. The subjects on the program were of common interest to general practitioners and school physicians; but a notice of special interest to the members of the Section on School Physicians was "A discussion of Current Problems in School Health Work", by Dr. Allen G. Ireland, Director of Physical and Health Education, State Department of Public Instruction of New Jersey.

ALLEN G. IRELAND, M.D.

PRESIDENT'S BANQUET AND BALL

The social event of the Annual Meeting was the President's Banquet and Ball held on the evening of Wednesday, June 6, with a committee of the Woman's Auxiliary as hostesses to the 250 members and guests who were present. Dr. William J. Carrington, Atlantic City, Chairman of the Committee on Program and

Arrangements, presided with humor and grace. The after-dinner speaker was Dr. James J. Walsh, Dean Emeritus of Fordham University, who spoke wittily on "Funny Things That Cure People".

The banquet was followed with dancing, the floor being crowded for hours.

SCIENTIFIC EXHIBIT

A scientific exhibit of high merit was brought together by a committee consisting of Dr. John W. Gray, Newark, Chairman; Geo. S. Reitter, M.D., Vice Chairman, East Orange; Harrison S. Martland, M.D., Newark; Asher Yaguda, M.D., Newark; H. R. Casilli, M.D., Elizabeth; Robert A. Kilduffe, M.D., Atlantic City, and W. W. Maver, M.D., Jersey City.

A description of the exhibits is printed in The Journal of June, 1934, page 357.

Forty-one exhibits were shown, all of them being by New Jersey physicians, or hospitals, or laboratories. Some of them were taken to Cleveland and shown at the meeting of the American Medical Association, which began on June 11, 1934.

ART AND HOBBY EXHIBIT

The Society conducted an Art and Hobby Exhibit consisting of artistic products made or collected by members of the Society or their immediate families. The committee in charge of the exhibit was as follows:

Dr. William K. Campbell, Chairman, 96 Third Ave., Long Branch
 Mrs. A. H. Lippincott, 406 Cooper St., Camden
 Mrs. R. A. Shirrefs, 348 Elmora Ave., Elizabeth
 Mrs. Norton A. Wilson
 Mrs. H. V. Hubbard, 121 East 7th St., Plainfield.
 Dr. H. B. Orton, 23 Commerce St., Newark
 Dr. Solomon S. Bauch, 31 W. 11th St., New York City
 Dr. M. J. Kaufman, 103 Lyons Ave., Newark
 Dr. C. D. Martinetti, 311 Central Ave., Orange
 Dr. Lancelot Ely, Somerville
 Dr. F. J. Hughes, 706 Park Ave., Plainfield
 Dr. H. F. Johnson, 734 Park Ave., Plainfield
 Dr. Milton A. Shangle, 34 Prince St., Elizabeth
 Dr. C. C. Beling, 111 Clinton Ave., Newark
 Dr. Emory Bokor, 544 Springfield Ave., Newark

A list of the exhibitors, 21 in number, and the articles shown, was printed in the June Journal, page 359.

The following report of the exhibit was submitted by Dr. William K. Campbell, the Chairman:

ART AND HOBBY EXHIBIT

The following is a report on the Art and Hobby Exhibit for the Annual Meeting of the State Society in 1934:

Your committee was asked by President Quigley to proceed with the preparation of an exhibit, in a letter to the Chairman, Dr. W. K. Campbell, on March 27, 1934. The 1933 committee was called together at the Academy of Medicine Building in Newark on April 19, at 4:30 p. m., and at this meeting were present Mrs. H. V. Hubbard, President of the State Auxiliary, and Mrs. William B. Gray, Secretary of the State Auxiliary; President F. J. Quigley, President-Elect Lancelot Ely, Dr. Wilkes, the Executive Secretary; Dr. Overton, the Editor of the Journal; Dr. Kaufman, Dr. Bauch, Dr. Bokor, Dr. Hughes and Dr. Campbell.

Dr. Campbell was made Chairman, Dr. Bokor, Secretary, for the committee. After discussing plans for the exhibit to be held at the Annual Meeting in June, Drs. C. C. Beling and Emory Bokor were added to the committee.

It was decided to have sent to each county society and to each county Woman's Auxiliary, a sufficient number of entry blanks and a letter asking them to endeavor to get as many of their members as were interested in some hobby to enter

examples of their work in the forthcoming exhibit. These were sent from the Executive Secretary's office. In addition, your Chairman wrote a letter to each county society and to each county auxiliary, and to each of the twenty-seven exhibitors of 1933 asking them to make exhibits this year. Through inquiry your Chairman was able to discover a few individual physicians who had not exhibited but who had hobbies, and wrote them personal letters requesting them to exhibit.

On May 31, your Chairman went to Haddon Hall, Atlantic City, in order to make final arrangements for the exhibit. He rented three show cases, and after planning the lay-out for the Mandarin Room, found it would be necessary to have some form of covering for the racks on which pictures would be hung. He therefore ordered, through the hotel, a roll of 36" wrapping paper and made arrangements for renting some draperies to cover certain tables on which to place sculptures.

On June 5 your committee met in the Mandarin Room at 10:30 a. m. and proceeded to arrange the exhibits. As the wrapping paper to cover the racks had not arrived, and still had not arrived at 11:30, it was necessary to send one of the committee to buy covering for the racks.

The exhibits were all placed by 2 o'clock and members of the Society were coming in to view the exhibits.

There were twenty-four exhibitors. There were exhibits of oil paintings, photography, sculpture, modeling, prehistoric art, collections of bookplates, Indian pottery, rugs, and religious objects, antiques, china painting, and inventions.

The Exhibit was kept open from 2 p. m. to 6 p. m. and from 7 to 11 p. m. on June 5.; from 10 a. m. to 7 p. m. on June 6; from 10 a. m. to 4 p. m. on June 7.

On June 6 at 4 p. m. Mrs. H. Corbusler gave us an hour's talk on the art and religion of the Indians of the Southwest and demonstrated her very large collection of Indian pottery, both ancient and modern, ancient and modern Indian rugs, and katchinka dolls, which play a part in the religion of certain Indian tribes of the Southwest; also paintings showing their religious costumes and ceremonies. There was quite a large attendance at this lecture and much interest was manifest.

Your chairman wishes to thank, on behalf of the Society, those who took the trouble to bring or send exhibits, and particularly wishes to thank Drs. Bokor and Kaufman for sacrificing their time by staying in the exhibit room the greater part of the time of the exhibit.

We also wish to thank particularly the Atlantic City Woman's Auxiliary who, at the request of Mrs. Hubbard, had at all times several of their members in attendance to act as guides and hostesses.

I am enclosing herewith statement of the expenses of the committee. The total direct cost, i. e., money spent by the committee itself, was \$45.60, aside from the entry blanks which were gotten out by the Executive Secretary's office.

Cloth covering for frames	\$5.40
Man unpacking and packing exhibits, and covering frames	1.00
Draperies for covering tables	3.00
Roll of paper	4.50
Rental of typewriter at exhibit	2.50
Postage, letters, etc.	4.20
Rental of cases and hauling	25.00
	<hr/>
	\$45.60

A considerable part of the roll of paper was saved and was marked "Property of Art and Hobby Exhibit, Medical Society of New Jersey" and stored

with other effects of the Society at Haddon Hall for use next year. The cloth covering for the frames was removed and is in the possession of the Chairman, for the purpose of using again next year.

Your committee wishes to report that we believe the Art and Hobby Exhibit created a considerable amount of interest and does offer some relaxation to the members between sessions and at odd times, at a very low cost, as compared with other entertainment that can be provided by the Society.

Respectfully submitted,

W. M. K. CAMPBELL, *Chairman*,
Art and Hobby Exhibit Committee.

COMMERCIAL EXHIBIT

Twenty-one manufacturers and dealers in products of interest to physicians exhibited their wares in booths near the registration

table. A list of the coöperating firms and a description of their products was printed in the June Journal, page 360.

THE WOMAN'S AUXILIARY

The seventh annual meeting of the Woman's Auxiliary to The Medical Society of New Jersey was held in connection with the 168th Annual Meeting of the parent society, on June 6, 1934, at Haddon Hall, Atlantic City, with the President, Mrs. Harry V. Hubbard, Plainfield, in the chair.

The President gave the following report:

ANNUAL REPORT OF THE WOMAN'S AUXILIARY

June 6, 1934

As my term of office closes I cannot help thinking of the many things which I might have done, but which I am leaving undone. I feel, however, that with the splendid coöperation of the Executive Board commendable progress has been made in Auxiliary work. We hope what we have done will help our successors carry on.

Real progress has been made in putting before the counties the three aims of the Auxiliary; namely, to combat false advertising of food and drugs, to further good medical legislation, and to establish a Speakers' Bureau. I realized how wonderfully the counties were responding when I heard the reports at their meetings which I attended.

Those visits are one of the many pleasures that go with the office of President. During the year I have visited Monmouth, Essex, Camden, Somerset, Burlington, Hudson, Bergen, Passaic and Atlantic County Auxiliary meetings, Mercer County Auxiliary at the Mid-Winter Board meeting and Essex at the Spring Board meeting. The Fall Board meeting was held in my home. I also attended one Federation meeting. The memories of

the group of friends met at each place are even sweeter than the beautiful flowers they presented to me. I have made eleven such visits. attended three board meetings and numerous committee meetings, written ninety letters, telephoned, telegraphed and sent packages over the State.

Although our membership has fallen off slightly to 658. I know the quality of our members cannot be improved upon since I have met so many charming women. The paid-up membership in the counties runs from 5 to 140. Two-thirds of our counties are organized and those counties contain 85 per cent of the population of our State. But our goal should be 100 per cent organized.

Our activities have been social meetings, reciprocity meetings, luncheons, benefits, card parties and charity work. Topics for the meetings reported have been Health of the School Child and Pre-School Examinations (3), Russian or Red Medicine (1), Reciprocity Meetings (23), institutions visited (5), How the State Cares for the Sick (1), Travel Talks (1), Welfare Work (1), Smoke Abatement (1), Licensure of Physicians (1), Communicable Diseases (1), Speakers' Bureaus organized (2), and many others.

I am pleased to express my sincere thanks to the officers and committee chairmen who have stood by and served the Auxiliary so efficiently. I also wish to thank the County Presidents, who have shown such splendid leadership. They are the kingpins in the structure of the State Auxiliary. I take this opportunity to thank Dr. Quigley and our Advisory Board or Council who have never failed to help us plan our work and execute it, guiding us safely through the year. And last but not least I thank Mrs. Salasin, Dr. Carrington, the Atlantic

County women and the Pages who have made the success of this meeting possible.

If any of you are ever asked by the Nominating Committee to become President, I hope you "will choose to run". Then you will realize how great a reward are the pleasures and friendships which will endure in my memory as long as I live.

Other officers presented their annual reports, as follows:

Recording Secretary, Mrs. W. H. Gillium, Asbury Park.

Corresponding Secretary, Mrs. W. B. Gray, Plainfield (read by Mrs. Gillium, Secretary).

Treasurer, Mrs. Edward Clarke, Englewood.

The following Chairmen gave reports:

Publicity, Mrs. James North, Margate.

Program, Mrs. A. Dunbar Hutchinson, Trenton.

Public Health, Mrs. Don Eppler, Newark.

Entertainment, Mrs. Samuel Salasin, Atlantic City

Credentials, Mrs. James Mason, Atlantic City.

Public Relations, Mrs. A. M. Shultz, Paterson.

Legislation, Mrs. James McGuire, Trenton.

Hygeia, Mrs. Thomas McConaghy, Camden.

Widows and Orphans, Mrs. Theodore Teimer, Newark.

Historian, Mrs. James Hunter, Westville.

Mrs. Hunter, Mrs. Gray and Mrs. Shultz were unable to attend the meeting and present their reports.

The following County Presidents presented their reports personally:

Atlantic, Mrs. Joseph Poland.

Burlington, Mrs. G. H. McDonnel.

Essex, Mrs. F. J. McCauley.

Hudson, Mrs. Frank Nicholson.

Monmouth, Mrs. Walter Gosling.

Passaic, Mrs. William Dwyer.

Union, Mrs. H. H. Bowles.

Bergen, Mrs. S. Alexander.

Camden, Mrs. A. Haines Lippincott.

Gloucester, Mrs. E. E. Downs.

Mercer, Mrs. William C. Ivins.

Ocean, Mrs. A. Woodhouse.

Somerset, Mrs. Lancelot Ely.

Mrs. F. A. Kinch, Westfield, conducted a Memorial Service, assisted by Miss Mary Lea Davis, Camden. The members who have passed away this year were Mrs. Emerson Haines, of Monmouth County; Mrs. Francis McConaughy, of Somerset; Mrs. J. Bennett Morrison, of Essex; Mrs. Mooney, of Hudson; Mrs. Rush Neer and Mrs. William Flitcroft, of Passaic. This is the first year such a service has been held.

Mrs. A. Haines Lippincott gave the report of the Nominating Committee, members of which were Mrs. Walter Gosling, Mrs. H. Hunter Scott, Mrs. Charles F. Adams and Mrs. Norman Currie.

The following officers were elected for the ensuing year:

President, Mrs. A. J. Casselman, Camden.

President-Elect, Mrs. F. A. Kinch, Westfield.

First Vice-President, Mrs. William Friele, Jersey City.

Second Vice-President, Mrs. James Mason, Atlantic City.

Third Vice-President, Mrs. Robert Glenn Stone, Trenton.

Recording Secretary, Mrs. Marcus Newcomb, Woodbury.

Treasurer, Mrs. Edward Clarke, Englewood.

Directors: Mrs. Elwood Downs, Woodbury; Mrs. Edward G. Waters, Jersey City.

After their election, Mrs. Hubbard greeted and introduced the new officers and the President, Mrs. A. J. Casselman, of Camden, who had served as President-Elect for a year, and presented the gavel to her.

Mrs. Casselman addressed the meeting, named those she has appointed to the various committees, and then adjourned the meeting.

At one o'clock the Auxiliary entertained the members of the Medical Society and friends at a luncheon in the Rutland Room of Haddon Hall. About one hundred attended. The guests of honor were Mrs. Robert Tomlinson, of Wilmington, Delaware, who is the President-Elect of the Woman's Auxiliary to the American Medical Association; Mrs. A. J. Casselman, of Camden, President of the Woman's Auxiliary to the Medical Society of New Jersey; Dr. Frederic Quigley, of Union City, President of the Medical Society of New Jersey the past year; and Dr. Lancelot Ely, who has just taken that office. Dr. Julius Levy was the guest speaker, describing the results of a state-wide survey of the immunization of children of the pre-school age.

Mrs. A. Haines Lippincott, the first President of this Auxiliary, presented the Past President's Pin to Mrs. Hubbard and welcomed her as the seventh member of the Past Presidents' Club. Mrs. Hubbard thanked the Auxiliary members for the gift, the honor and coöperation they had given her. She then presented her gift, a prize of two books, to the Auxiliary to Camden County for showing the best improvement in membership during the year. Mrs. Edward Pechin, President, accepted the prize. Mrs. Hubbard was toastmaster at the luncheon.

At four o'clock Mrs. Harold Corbusier, of Plainfield, gave an interesting talk at the Hobby Exhibit in the Mandarin Room, about her exhibit of American Indian pottery, rugs and baskets.

The Auxiliary had charge of the arrangements for the banquet and ball given in honor of President Quigley and President Ely. Two hundred forty-four guests attended. Dr. James Walsh, of New York, was the guest speaker. He talked about "The Funny Things That Cure Us". While at the table, the guests sang songs about the medical profession and some of those present, which were composed by Dr. William Carrington, the toastmaster, and were entertained by Mr. Thomas Huxselt, song leader, and Mr. Carlo Restivo, accordionist.

The following ladies will represent New Jersey at the national Auxiliary meetings in Cleveland June 11th to 15th as Delegates: Mrs. F. A. Kinch, Mrs. Ephraim Mulford and Mrs. Harry V. Hubbard.

(Signed) MRS. HARRY V. HUBBARD,
President.

MEETINGS OF THE COUNTY SOCIETIES

Atlantic County.—Meets second Friday evening monthly, except in June, July, August and September. Annual Meeting in December.

Bergen County.—Meets on second Tuesday each month, except July and August. Annual Meeting in January.

Burlington County.—Meets second Wednesday afternoon of January, March, May, September and November. Annual Meeting in November.

Camden County.—Meets first Tuesday in each month October to May inclusive, with an outing in June. Annual Meeting in October.

Cape May County.—Meets on first Tuesday in April and October. Annual Meeting in October.

Cumberland County.—Meets on the second Tuesday of January, April, July and October. Annual Meeting in October.

Essex County.—Annual Meeting is the second Thursday in October. Other meetings on the second Thursday of each month, November to May, inclusive, on call of the Council.

Gloucester County.—Regular meetings on the third Thursday of each month, except June, July and August. Annual Meeting in November. Annual Social Session in October.

Hudson County.—Meets first Tuesday evening of each month, October to May, inclusive. Annual Meeting in October.

Hunterdon County.—Meets on the fourth Tuesday of January, April, July and October, the latter being the Annual Meeting.

Mercer County.—Meets on the second Wednesday of each month, except July, August and September, at 8.30 p. m., in the Carteret Club at Tren-

ton. Annual Meeting in December. Annual Banquet in November.

Middlesex County.—Meets on the third Wednesday afternoon of each month, September to June inclusive. Annual Meeting in December.

Monmouth County.—Meets on the fourth Wednesday of each month from October to June inclusive. Annual Meeting on the Tuesday after the first Monday in December.

Morris County.—Meets on the third Thursday in March, June, September and December. Annual Meeting in September. Special meetings (1-3 yearly) for additional scientific discussions arranged by Executive Committee.

Ocean County.—Meets eight times a year, October to June, as called by the Secretary. (Details to be supplied later.)

Passaic County.—Meets on the second Thursday evening of each month, except June, July and August. Annual Meeting in October.

Salem County.—Meets on the second Wednesday in February, April, October and December. Annual Meeting in October. Social Meeting in May.

Somerset County.—Meets on the second Thursday evening in February, April, June, October and December. Annual Meeting in October.

Sussex County.—Annual Meeting on the second Tuesday in September; other meetings bi-monthly, September to May inclusive.

Union County.—Meets on the second Wednesday of February, April, October and December. Annual Meeting in October.

Warren County.—Meets on third Tuesday of January, April, July and October; the last named being the Annual Meeting.

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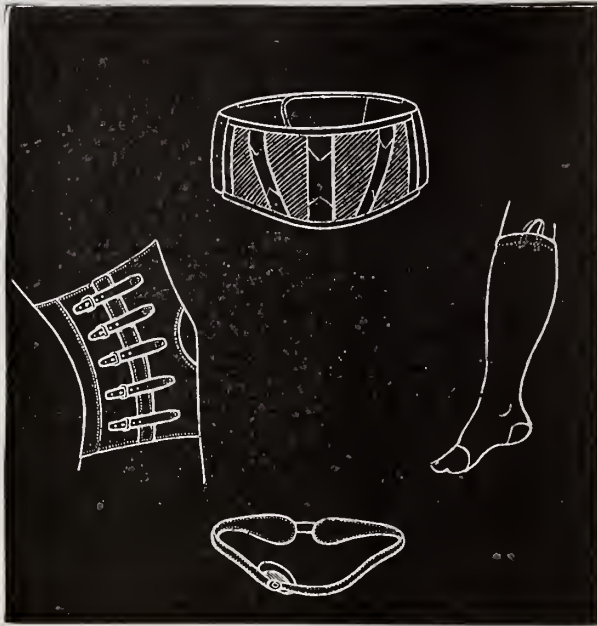
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CONGENITAL MALFORMATIONS

The following announcement has been received from Dr. Douglas P. Murphy, of the Gynecean Hospital Institute of Gynecologic Research, of the University of Pennsylvania, Philadelphia, Pa.

"The Gynecean Hospital Institute of Gynecologic Research of the University of Pennsylvania is conducting an intensive study of families into which congenitally malformed individuals have been born.

"It is common for mothers of congenitally malformed infants to ask: 'If I should give birth again, what is the chance that the next child will also be defective?' The Gynecean Hospital Institute has undertaken a study of families possessing congenitally malformed children in an attempt to answer this question.

"Important objects of this investigation of mal-

formations are: a, To determine their frequency of recurrence in the same family; b, to study the nature of the defects; c, to throw light upon their etiology.

"Families possessing one congenitally malformed child have been located through death certificates. Data from this source are being augmented by those from their hospital records, their family physicians, and from home visits. Undoubtedly, some of these families will exhibit recurrences of malformations, but the number of the latter families probably will be small. In order to locate as many additional families as possible, which possess two or more defective offspring, it seems necessary to broadcast the fact that the study is being made. For this purpose, we are asking the assistance of physicians, medical societies, and editors."

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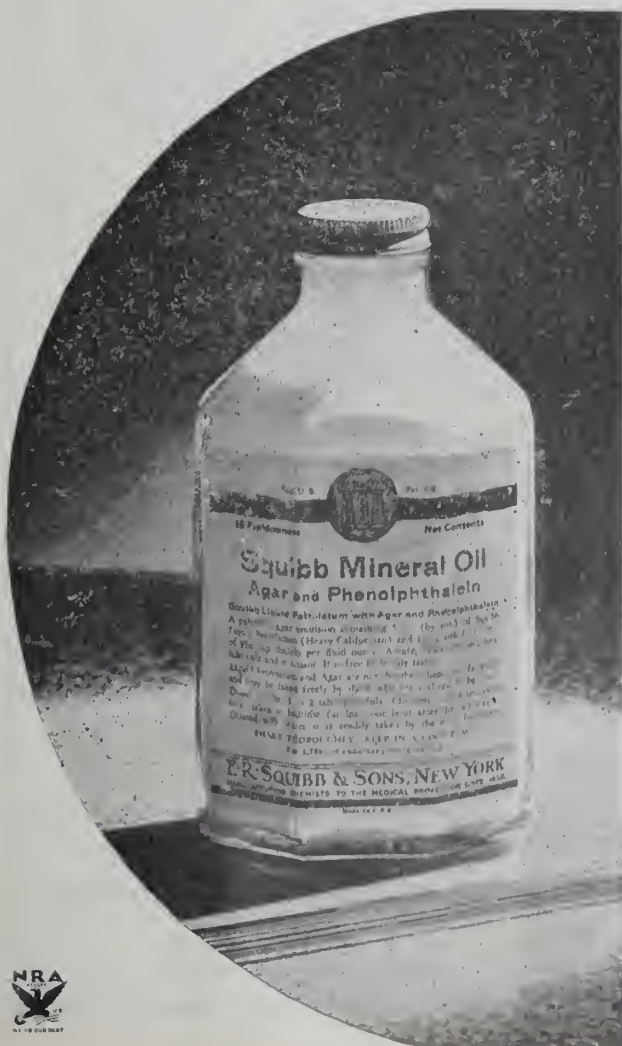
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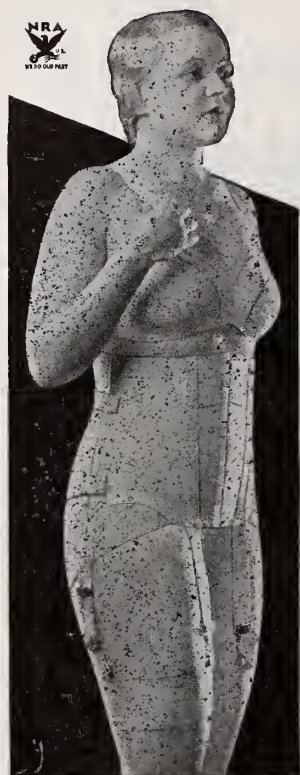
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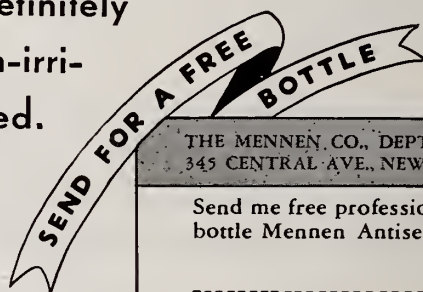
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



EDITOR OF
THE JOURNAL
FRANK OVERTON, M.D., Dr. P.H.

OFFICES OF THE SOCIETY—137 EAST STATE STREET, TRENTON, N. J., TEL. 9330
EXECUTIVE SECRETARY—LEROY A. WILKES, M.D.

Each member of the State Society is entitled to receive a copy of THE JOURNAL every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.

Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.

Officers, Trustees, Councilors and Committees of the Society are listed on page xx of the Advertising Section.

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AUGUST, 1934

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EDITORIALS

Preserve Your Journals

This August number of The Journal with its 56 page supplement of "Transactions" completes the record of the Annual Meeting of The Medical Society of New Jersey, which took place during the first week of June. The Annual Meeting has necessarily been a major feature of The Journal both before and after the event. The reports of the officers and committees filled forty pages, or two-thirds of the space of the May number. Seven pages of the June issue were devoted to a news accounting of the meeting, and ten pages to the addresses of the President and President-Elect.

The July Journal contains the seven-page report of the monumental study of contract practice and dispensary abuses which was made by Dr. T. K. Lewis and his colleagues on the Sub-Committee on Medical Practice of the Welfare Committee. This report is a permanent source of information to which every member will have occasion to refer.

Now comes the fifty-six-page supplement containing the full minutes of the House of Delegates. It has been carefully prepared for accurate and easy reading with numbered paragraphs and headings, so that every action can be readily followed and studied. References

are also made to the page in which every annual report may be found in the May Journal.

The "Transactions" will be in constant use because of the great number of facts contained in them. Every officer and committeeman of the State Society and of each County Society will have occasion to consult the Transactions frequently in order to conform his own activity with the policies which have been developed by the medical leaders and approved by the members assembled in their annual conclave.

Then too there is the fifty-four page supplement to the May number containing the official list of the fellows, officers, and delegates of the State Society, and the members of the County Societies. This supplement will probably be used more widely and constantly than any other part of The Journal.

The Journals and their supplements are of such permanent value that an effort should be made to provide every member with the means of preserving them. The State Society might well consider the purchase of a labelled box for each member, in which he can file each publication as it arrives, and place it in his book-case where it can be found instantly when it is wanted. The distribution of the boxes could be a project of every county society.

The Reception Committee

Every County Medical Society needs a *Reception Committee* to greet the members as they arrive and introduce them to the other members, and if necessary start them talking on some matter of common interest.

Nothing is so disheartening to an occasional attendant as to enter the meeting room and find a dozen members sitting around with empty chairs between them, waiting for something to happen.

Did you ever make a timid approach to a member and ask him, "Who is that new fellow over there in the corner?" and be told, "I guess he must be the new doctor that came to Jonesburg last year."

Did it ever occur to you that it is your duty to go over to him and say, "I am Dr. Smith. Come over and let me introduce you to Dr. Robinson, who gets over your way occasionally."

It may be that neither doctor is a ready talker. It is then your duty to start a conversation. Any subject will do, so long as it is something worth talking about. The chances are that the two will quickly find a common subject and that each will be delighted to know the other, and will discover a common interest in business or sport, or hobby, or social contacts. It is not at all necessary that the approach be through medicine—that subject will come up afterward. The point is to make the newcomer feel at home—and the old member too for that matter.

The President and the Secretary are the official handshakers of the Society, and can approach any member or guest. If they are afraid to greet a newcomer, how much more afraid are the rank and file of members who feel no personal responsibility for creating or maintaining interest in the meetings? The one big thing that any President and Secretary can do is to try to make everybody in the room feel at home with his neighbor in the next chair. That feeling will counterbalance a large number of defects in the actual program of the meeting. After all, the great compelling attraction of a county medical society is the engaging personalities of a few members who are always ready to talk with their colleagues whether they know them or not.

There are always a few members who are the "life of the meeting". These members often constitute themselves an unofficial reception committee as they go from person to person and inject the more timid into a group of acquaintances who are so engrossed with those of their own set that they do not think about their more retiring comrades who need only the invitation and then become one of the party. Why not appoint two or three of these members on a reception committee?

The duties of the reception committee do not end when the meeting is called to order. It is a growing custom that refreshments are served after the meeting. A great opportunity of the reception committee is that of seating the newcomer with a congenial companion. The President and Secretary feel in duty bound to take their places at the head table with the guest speakers. One officer can attend to that duty, while the other sees that the less aggressive members are seated with a congenial group, even asking a talkative member to look after one who needs an invitation to join a party of congenial pals. Every member of a reception committee can infuse interest in the society by seeing that all are happily seated before he seats himself.

Sociability is an essential feature of every medical society. It is the mainspring of action by the organization, but it does not always develop spontaneously. It needs nurture. A few members have the social instinct, and will make themselves at home in any group. One with that instinct will introduce himself and say to his timid seatmate, "I am Dr. Brown from Four Corners." That will be a sufficient introduction to reveal a new source of interest which will inspire the occasional attendant to come to the meetings regularly.

This may seem to be a commonplace subject for an editorial; but it is of vital interest to all those leaders who seek to enlist the hearty cooperation of all the doctors of the county. Of course, the best Society is that in which every member is active on the reception committee. Every Society can reach that happy state if the President will make sociability a major project of his administration.

The Woman's Auxiliary

The reports of the officers and committees of the Woman's Auxiliary to The Medical Society of New Jersey given at its Annual Meeting on June 6, 1934, reveal latent possibilities of the usefulness of the organization. The place of the Auxiliary will be plainly apparent when the organization discovers an unoccupied field of activity in which it can render essential service to both the medical profession and the public. Its opportunity of peculiar value is to become the connecting link between the Medical Profession and the lay health organizations, especially in public health education.

DEFINITENESS OF AIM

The Medical Society of New Jersey is giving serious consideration to the project of "Popular Medical Education" by the standard means of newspaper articles, lectures, and the radio. This project has been promoted and operated extensively by the American Medical Association and the Medical Societies of several states, and by departments of health. But these efforts have lacked the essential element of *definiteness* in their application to local conditions. They have been like a barrage of cannon fire in the World War, when tons of ammunition were expended in producing each human casualty. On the other hand, General Jackson at New Orleans in 1815 secured a casualty with every pound of his ammunition, because each shot was aimed at an individual enemy who was in plain view.

PRE-EMPTION OF EDUCATIONAL WORK BY LAY ORGANIZATIONS

Popular medical education in New Jersey, as elsewhere throughout the United States, has already been extensively promoted by lay health organizations, such as parent-teacher associations, anti-tuberculosis leagues, and public health nursing societies. These groups of laymen have been inspired and often financed by endowed "Foundations" which have supplied unlimited quantities of literary and pictorial ammunition to be discharged in the general direction of a concealed enemy.

POPULARIZING THE COUNTY MEDICAL SOCIETY

The peculiar field of the Woman's Auxiliary is to supply a liaison group which shall be in intimate contact with the medical profession on the one hand, and the lay health organizations on the other. Physicians deplore amateur attempts to conduct health activities, such as diagnostic clinics, health lectures, and the mass x-raying of all school children; and they are ready to assist the lay organizations with their advice, and their time and professional services, *through their medical societies*. The Woman's Auxiliary is the natural group which can direct the lay promoters to an officer or committeeman of the County Medical Society whenever a new health movement is suggested by a lay health organization.

LIAISON PROJECT OF THE AUXILIARY

Auxiliary members are in the strategic position of contact with the doctors on the one hand, and with social leaders on the other. When a new health project is under consideration by a Parent-Teachers Association, for example, the doctor's wife can suggest a consultation with the county society representative in order to obtain the sanction and assistance of the medical profession. It is entirely proper that the members of the Auxiliary should talk freely of the attitude of the *Medical Society*, when she would properly hesitate to advise a consultation with an individual doctor.

A county auxiliary can take the opportunity to inject itself into every public health movement in its territory.

Every county and community has several local health movements under way; and there is an officer or committeeman of the county medical society available to give advice to the lay leaders. The peculiar opportunity of the Auxiliary is to approach the laymen and offer the services of the County Society in any movement promoted by a non-medical group.

The suggestion that the Auxiliary adopt the liaison project is offered to its leaders, and to the officers of The Medical Society of New Jersey.

Original Purpose of State Medical Societies

The Medical Societies of the older states were formed for the purpose of controlling the admission of candidates into the ranks of the medical profession. The Medical Society of New Jersey was founded on July 23, 1766, and the minutes of its early meetings contained frequent references to rules for the acceptance of apprentices to physicians. On May 5, 1767, it was voted that every apprentice should have competent knowledge of Latin and some "initiation in the Greek"; that no member shall take an apprentice for less than four years; and that the fee to be paid by the apprentice should be one hundred pounds, which was "very low, and no more than a bare acknowledgment for board during the above term". Admission into the Society was by an examination in the science and art of medicine.

On November 14, 1775, there is a minute that Dr. Thomas Hough, having presented credentials from the Faculty in Philadelphia, should be admitted a member when he obtains a license from general court entitling him to practice medicine in New Jersey.

The law of 1816 gave the State Medical Society the right to license practitioners after finding them qualified by an examination.

The Medical Society of the State of New York was founded in accordance with a law passed in 1806 conferring on the Society and its component County Societies the right to examine candidates for practice and to issue

licenses to those who were found worthy and well qualified.

The State Medical Society of Maryland still retains the evidence of its former prerogative to examine and license candidates by continuing its original name, "The Medical and Chirurgical Faculty of Maryland".

The Massachusetts Medical Society continues to require all candidates for membership to undergo an oral examination in the science and art of medicine conducted by the censors of the County Societies. During the last few years, the candidates have had to answer thirty questions resembling those submitted by licensing boards. Among the questions used on November 2, 1933, were the following:

Discuss the triangles of the neck.

Discuss tetanus.

Name and discuss the causes of coma.

What is the Ascheim-Zondek test?

What would you determine to be the onset of labor?

It might be supposed that the Massachusetts Medical Society would be an exclusive body, composed of only the more proficient practitioners. But the fact that Massachusetts enrolls seventy-three per cent of its practitioners of the State in its Medical Society—a percentage excelled by no other state, and equalled only by Iowa and Alabama.

New Jersey's Appeal to the American Medical Association

The House of Delegates of The Medical Society of New Jersey, at its meeting on June 7, endorsed the proposal which President Quigley put forth in his presidential address, that the New Jersey delegates present to the House of Delegates of the American Medical Association a request that the parent body devise a plan which should be an answer to the plans for sickness insurance and state medicine that are put forth by the "Foundations". Commenting on New Jersey's action, the August number of the *Virginia Medical*

Monthly, the official publication of the Medical Society of Virginia, says editorially:

"The Medical Society of New Jersey declared 'relative to the crisis of organized medicine' that 'the parent body of organized medicine, the American Medical Association', should immediately assume 'the leadership to meet the greatest threat that has ever been made to American medicine, to-wit, the menace of controlled medicine by the state'. Its delegates were instructed 'to use their best efforts to the end that a plan * * * to meet

this emergency be forthwith promulgated through the channels of the American Medical Association'.

"After hearing these resolutions, the House of Delegates on June 12th adopted the report of its Special Committee which, after reviewing to its own satisfaction the policies and conduct of the Association up to the present moment, put into the hands of the delegates a pamphlet entitled 'Sickness Insurance Problems in the United States' and calmly declared that it 'does not recommend any plan, but has abstracted from the pamphlet the following principles and suggests that they be followed by all constituent bodies of the American Medical Association as bases for the conduct of any social experiments that may be contemplated by them.'

"It will be another year before the American Medical Association in convention assembled has an opportunity to take a more definite stand. By that time the President of the United States probably will have given to the people of this country some type of social insurance, including old age pensions and unemployment benefits. It is to be hoped that organized medicine in this country will then know its mind well enough to be able to play a constructive part in this new and challenging field, especially in the origination of hospital and health insurance which are logical bi-products of future social legislation in this country.

"In a few weeks the Medical Society of Virginia will have another opportunity to declare its position on these questions. Will it take its stand by the side of such progressive states as Michigan and New Jersey?"

The Establishment of a Fee List

History repeats itself medically as well as politically, and human nature is still the same that it was a century and a half ago.

The very first action taken by the Medical Society on the day of its founding was the consideration of a fee list. The organization of the society was effected during the morning of July 23, 1766. At one o'clock the Society held its first formal meeting and proceeded at once to a consideration of

to draw up a "catalogue of such articles as would admit of a regular mode of charges".

The committee acted promptly and at six o'clock on that same day it reported a scale of fees whose preamble read:

"The mode of charging for medical and surgical services * * * it appearing that there was no law or custom throughout the Province (a matter greatly to be lamented) for the paying of regular fees for advice and attendance, except a certain small allowance per mile for riding in country places, by which means the practitioners have been under the necessity of laying something on their medicines * * * and this method being necessarily attended with much inconvenience from different practitioners pursuing different methods, often thereby proving a source of doubts between them and their employers * * * a patient suspecting injustice because he might find his bill in one form from one practitioner and in a different form from another, and this method also seeming to open a door to the imposition of quacks. To remedy these inconveniences * * * it was resolved to institute one general and uniform mode of charging."

"The New Jersey Medical Society * * * have separated themselves to a profession that not only deprives them of many comforts and indulgences which persons in other offices of life enjoy by being at the call of anyone, day or night, but also exposes them to many disagreeable scenes and often to great dangers from contagious diseases, etc., besides the great expense of education and the many painful years to be employed in preparatory studies as well as that of the science itself. They are in an especial manner entitled to a just and equitable reward for their services, at least to live by this their useful profession; * * * and have unanimously agreed to the following table * * * as they sincerely think are consistent with equity and by no means higher than the usual charges heretofore generally made. * * * And they do hereby bind and oblige themselves at all times hereafter to keep their accounts according to the rates therein settled and ascertained, till the Legislature shall interpose or some other happier method be devised for determining a matter so interesting both to the public and the profession."

Then follows the "Table of Rates and Fees" consisting of 130 items. The highest rate on the list was five pounds for "cutting for stone

A committee of four was at once appointed

in the bladder". The next highest rate was three pounds for "operation of the trepan"; and for eleven other operations including the extraction of a cataract, amputation of a breast, leg or arm, fistula in ano, and "delivering a woman in a preternatural case".

This list was at once adopted, but it came up for consideration at nearly every meeting of the society for several years, the society meeting every six months. The minutes of the second meeting, held on November 4, 1766, contain a record of the dissatisfaction of the people with the society:

"It was reported that the principal clamor of the inhabitants was owing to some improper expressions having escaped some member of this society in regard to visiting fees and other charges which had brought the society into disrepute with many persons who esteem it as an unjust scheme invented by the society to bring the inhabitants to terms. It was therefore moved that every member of the

society be at liberty to charge as each of them think proper till the next general meeting, by which time it was hoped that the publication of the laws of the society may have a tendency to remove the ill-grounded suspicion of the populace."

This motion met with considerable opposition, but was finally carried. The rates came up at every meeting thereafter until November 13, 1770, when it was voted that "the consideration of the Bill of Rates be deferred sine die, to be revived at some future time, if necessary". The fee list was suddenly revived on November 1, 1785, and was adopted with some changes on May 2, 1786, the record being only a few lines in length.

The Society in its early days took twenty years in adopting its first fee list. Twenty weeks of these modern days should be ample time for the Society of 1934 to devise a satisfactory fee list and place it in operation.

The Seal of the Society

A new plate of the Seal of the Medical Society of New Jersey has been drawn and etched and was first used on the editorial page of the July Journal. It also appears on the stationery that has been printed recently.

Almost the only change in the seal was the elimination of its dark background which looked all right on a seal two or three inches in diameter but did not stand reduction to a one-inch size. The seal is now neat and legible and of a convenient size.

The seal represents the oracle in the Temple of Apollo, the supreme god of health and

vigor. The High Priest is shown delivering a prophesy as he stands beside the altar. High above him shines the clear light of inspiration. The Latin inscription above the columns may be translated "A bearer of good work around the world am I called".

The inscription on the altar is an abbreviation for "*cortina merces anti*"—the oracle of Apollo is opposed to commercialism—*cortina* being the technical name for the oracle of Apollo.

The inscription below the altar may be translated "New Jersey Medical Society Seal".

Reorganizations

This is the season of reorganizing medical societies in the State of New Jersey. The counties complete their reorganization at the beginning of the year, but the State Society begins its new year immediately after the Annual Meeting. There will be a few retirements, some promotions, and many new accessions to the groups of workers. But the Society has wisely provided for a continuity of policies and actions by making terms of office more than

one year, so that experienced officers are always available. This provides a commendable element of conservatism; but it also affords the opportunity to willing workers to exercise their gifts and share in the great work in keeping the medical profession fully up to date in conformity with the spirit of these progressive times.

New Jersey probably leads the states in the proportion of active members in positions of responsibility and honor.

ORIGINAL ARTICLES

ADULT TUBERCULOSIS IN CHILDREN AND ITS TREATMENT BY COMPRESSION THERAPY

By SAMUEL B. ENGLISH, M.D., and MAX GROSS, M.D., Glen Gardner, N. J.

From the New Jersey State Sanatorium, Glen Gardner, N. J. Read at the 168th Annual Session of the New Jersey State Medical Society at Atlantic City, June 6, 1934.

Great emphasis has been placed on the importance of the tuberculin reaction for the detection of tuberculosis in children. The epidermal (Pirquet) as well as the intradermal (Mantoux) tests are used in most of this work. By such means the incidence of tuberculosis among children has been exhaustively investigated by Chadwick and Zacks,⁽¹⁾ Myers,⁽²⁾ Korns,⁽³⁾ Slater,⁽⁴⁾ Hetherington, McPhedran, Landis and Opie,⁽⁵⁾ and scores of others. These investigators have shown the incidence of childhood type of tuberculosis to vary from 10 per cent in the rural communities to 90 per cent in the larger cities. It is interesting to note that in the routine testing examinations, many children have been found to have adult type of the disease, some of whom had no clinical symptoms. The incidence of adult disease has increased as the study has been extended to the junior high and high school children.⁽⁶⁾

A diagnostic brochure on the childhood type of tuberculosis has been printed by the National Tuberculosis Association, edited by Chadwick, et al,⁽⁷⁾ whereby the tuberculin tests have been standardized. Chief emphasis was placed upon the Mantoux test because of its uniform dosage and greater accuracy as compared to the Pirquet test.

HYPERSENSITIVENESS

A positive test represents an allergic reaction to the tuberculo-protein; and a 3 or 4 plus reaction represents a greater degree of hypersensitiveness than a 1 plus or 2 plus. A child showing great hypersensitivity stands a graver chance of spread of the disease, whether it be a first infection or a re-infection.

Myers⁽⁸⁾ in a recent paper points out the two great dangers following the first infection. One is that the first infection results in *hyper-*

sensitiveness of the body tissues to the tuberculo-protein, which makes either an endogenous or an exogenous re-infection dangerous. Secondly, the foci themselves are a danger because a primary focus may *liberate tubercule bacilli* to any point of the body—to the bronchial tree, the lymphatic system, the parenchyma of the lung, the blood vessels, the brain, etc., thereby causing an endogenous infection. It becomes then self-evident that a first infection is not a good thing to have, contrary to the prevalent belief that a first infection protects against future spread.

DIAGNOSIS

Great stress has been placed upon the children showing a 3+ or 4+ tuberculin reaction in the Glen Gardner Institution for the past years by the senior author (S. B. E.). Consequently only these types of children have been admitted into the children's division of the State Sanatorium. We feel that such reactors need the care and strict supervision in a sanatorium provided for the care and treatment of childhood type of tuberculosis, as ours is. As result of such plan a much sicker child is admitted to this institution for the past two and a half years as compared with the admissions prior to this plan. Needless to say, a few cases of adult disease in children are thus admitted who have no history of contact; or on the other hand, having a history of exposure, have no clinical signs or symptoms whatsoever. It is often surprising to the family to be told that the child harbors adult disease when that child while at home had no complaints. Numerous instances can thus be cited.

CHILDHOOD TYPE OF INFECTION

Next of importance to the tuberculin reaction is the use of the x-ray for diagnosis. The

x-ray has greatly facilitated the differentiation of the childhood from the adult type in children. It is often difficult to differentiate caseous foci with the roentgenograms, but if these foci are massive, they can be seen. Often calcified foci cannot be discerned in a flat plate of the chest, but can be seen by the lateral or oblique views, as recommended by McPhedran.⁽⁹⁾ Since foci may be found behind the heart or in the mediastinal regions, some lesions may be seen anywhere else in the body, such as the neck and the abdomen.

In a first childhood infection the lesion may be anywhere in the parenchyma of the lungs with involvement of the hilum and tracheo-bronchial glands. Healing of a first infection is usually by the absorption of the exudate and subsequent deposition of calcium salts. Rarely does such a lesion go on to cavitation. On the other hand, the adult type usually starts in the sub-apices of the lungs without being accompanied by caseation or calcification of the hilum and tracheo-bronchial glands. Calcification in the lung field and hilum glands is good evidence of a first infection.

Opie⁽¹⁰⁾ has shown that an adult tuberculosis is almost always preceded by a childhood infection. Rathburn⁽¹¹⁾ has found that among the children of high school age developing adult disease 50 per cent show calcification, evidence of a latent childhood infection. He furthermore states that the 3 or 4 per cent of those harboring a first infection furnish 75 per cent of the adult disease in the teen ages. Myers and Kernkamp⁽¹²⁾ have found that among their 242 cases of adult disease in the teen ages, 60 per cent show evidence of calcification. Of the 27 cases concerned in this report having adult destructive tuberculosis (between 6 and 14 years of age), all of them show evidence of first infection. Stewart⁽¹³⁾ has observed a group of 579 positive Mantoux reactors, of these 13 cases developed adult disease, being followed from a period of less than a year to 11 years. These subapical cases were repeatedly observed by roentgenograms during the period of observation progressing to cavitation. In no case did he notice a reactivation of the original focus, but the spread was found in the contralateral lung. In our

series of 38 cases admitted to the institution for the past three years 34 had the adult lesion in the contralateral lung. Generally speaking, it seems that the first infection has prepared an allergic field whereby a more receptive soil is provided, so that re-infection produces with greater ease the adult form.

The adult form of tuberculosis may remain quiescent for any period of time without giving symptoms. Not infrequently one finds cases with minimal or moderately advanced disease with no physical findings. Hence, minimal tuberculosis may be easily overlooked. The majority of cases of youths in their early teen ages having signs or symptoms are usually in a moderate to far advanced condition. This is particularly true in our series of cases, 8 of which had moderately advanced tuberculosis, 17 far advanced, and only 2 minimal.

In a group of 38 cases observed here for the last three years, ranging in age from 5½ to 14 years, 23.7 per cent were minimal, 26.3 per cent moderately advanced and 50 per cent far advanced on first examination. In a series of cases reported by Myers and Kernkamp,⁽¹²⁾ 22.4 per cent were minimal, 25.2 moderately advanced, 46.2 far advanced on first examination.

MORTALITY IN ADULT TYPE OF TUBERCULOSIS IN CHILDREN

The treatment of the adult form of tuberculosis in children has been very unsatisfactory because the disease has been invariably fatal. The mortality of those harboring activity is appalling. All men doing extensive work in this field agree that the prognosis in children with moderately advanced to far advanced tuberculosis is very grave. Rest and strict sanatorium regime will not prevent progression of the disease in the majority of the cases. The treatment must be more drastic than mere rest and ordinary sanatorium care. Our only hope of any effective treatment is some form of *compression therapy* in the earlier types of cases. Earlier recognition of these cases is of paramount importance. Unfortunately, many cases, in fact most of the cases seen here, were in the far advanced stage with all the classical signs, symptoms, and

laboratory findings. Even such cases as these should not be deprived of some form of therapeutic compression either pneumothorax, phrenicectomy, or a combination of both. These cases are hopelessly sick; and if left alone they would die. Since the adult form of disease in children is not different from that in adults, there is no reason why such children should not get the benefit of pneumothorax allotted to the others. There will probably be just as many disappointments with collapse therapy in children as there are with adults.

In a series of cases studied by Opitz⁽¹⁴⁾ the prognosis of manifest open pulmonary tuberculosis in children was poor. The children between the ages of 12 and 16 years are especially subject to open tuberculosis, and according to the statistics only 5 or 6 per cent of these children over 10 years are still alive. Such poor results explain the substitution of active therapy for conservative treatment. He believes that the disappearance of fever, expectoration, and cough, and the absence of bacilli in the sputum are not identical with a cure; but a prolongation of life must be considered as evidence of progress in therapy. In the majority of cases a fatal outcome occurs during the first few years after artificial pneumothorax; and if the patient survives the first four years, the prognosis is good in 90 per cent of the cases. The author claims that artificial pneumothorax saves some patients who would have died in spite of a conservative treatment. While conservative treatment is followed by a 10 per cent recovery in the open cases, the modern methods of pulmonary collapse produce permanent cures in 25 to 50 per cent. He suggests in the early infiltrative cases frequent watching with roentgenograms because of the frequent extension of the disease, especially in children over 9 years. In 77 per cent of the cases, open pulmonary tuberculosis develops from a so-called early infiltration. He therefore urges the early institution of treatment, its sufficiently long duration being essential for good results. Absence of tubercle bacilli in the sputum does not excuse procrastination.

Hetherington⁽¹⁵⁾ has shown that apical le-

sions of slight extent may do well under a strict rest regime. However, more extensive apical lesions giving rise to trivial signs or symptoms are likely to progress unless treated. In a check-up of manifest apical tuberculosis in school children reexamined two and a half to four years after their first examination, he found that two remained quiescent and four showed progression. In the latent apical tuberculosis six remained quiescent and two showed progression. There are a number of cases of subapical lesions in our sanatorium that progressed to cavitation in spite of the strict supervision of bed rest, high caloric diets, vitamins, etc. In such cases one feels sorry not to have given them the benefit of therapeutic compression because of the later formation of adhesions and the ultimate failure in securing the compression of such diseased areas. Unfortunately there is no guide whereby one can pick out those that will be favorably influenced, since there are cases that will heal by strict rest regime plus other factors, and also those that will progress to a fatal termination. Our problem lies therefore in the early recognition of the progressive cases, and the immediate institution of artificial pneumothorax or some other forms of surgical compression.

EVIDENCE FAVORING COLLAPSE THERAPY

In reviewing the literature of collapse therapy one meets a great deal with optimism as well as pessimism as regards the use of artificial pneumothorax in children. Casetta⁽¹⁶⁾ made a comprehensive study of the medical literature in regards to the therapeutic effect of pneumothorax. He points out that the mechanism of action of pneumothorax is the same in children as in adults. The encapsulation and walling off of the foci with fibrous bands following a process of cicatrization is slow in children. He cites the work of Cantani and Carpi, who found that the immobility and the pulmonary compression can not alone be referred to as the only factors of benefit; but that the remote effects of pneumothorax on other foci play a rôle in causing such improvement, such as succeeding onset of pleurisy causing an immunity reaction. The expulsion produced by the compression induces a rela-

tive cleansing of the infectious foci, and a freeing of the pulmonary content of tubercle bacilli whether they exist alone or in symbiosis with other organisms. He also believes that the persistence of a relatively pure tuberculous infection exerts a beneficial influence on the phenomena of local and general defense in a child. Consequently there is a local and general reaction, mechanical, anti-toxic and anti-bacterial.

PHYSIOLOGICAL FUNCTIONS AFTER COLLAPSE

It was at first thought that the mechanical effect of compression therapy was the closure of the cavity, or of the bronchi which conduct air into the cavity. But it was later shown that the physiological effects were the more important, such as the effect on the blood and lymph in the lungs. Expectoration is not impeded by compression pneumothorax.

Brauer⁽⁴⁷⁾ points out that there is certain amount of gaseous exchange in lung which is placed at rest. A patient with a good therapeutic collapse breathes normally and feels at ease, and shows no cyanosis while on fairly extensive exercise. When collapse therapy was first applied, there was considerable anxiety lest with collapse of one lung, the contralateral lung would have too much work thrown on it. When a normal man is in complete repose, only from 5 to 10 per cent of the maximum ventilation takes place. When a complete unilateral collapse of the lung is done, only from 10 to 20 per cent of the maximum ventilation is used. The collapse of the lung does not produce much interference with oxygenation.

The blood circulation is diminished in the lung which is moderately compressed, but it may almost cease with bilateral collapse. The nutrient blood vessels are not effected by the collapse, and hence nutrition does not suffer. There may be stasis of the blood content of the lung; however, the blood flow may not be necessarily lessened. Generally, the blood that does not pass through the compressed lung passes through the contralateral lung to be arterialized. It has been shown that more perfect arterialization of the total blood takes place after collapse of a lung. There is a definite deficient oxygenation in a diseased lung.

A respiratory insufficiency is usually removed by the establishment of a unilateral pneumothorax when the circulation is interrupted in the diseased lung and forced to pass through the other lung in which it is able to get enough oxygen.

Interesting is the fact that the lymph circulation out of the lung is extensively blocked by the compression. In the first few days there is frequently a febrile reaction due to the expulsion of a toxin-laden lymph into the blood stream simulating the effects of an overdose of tuberculin. As a result, such blockage leads to a reflux of lymph with pleural irritation and the formation of adhesions. The residual air is very slightly affected, but there is a distinct decrease in the vital capacity, especially of the complementary air in unilateral collapse. There is little demand on the respiratory reserves; but in bilateral compression pneumothorax the respiratory reserve, residual air as well the complementary air, is very considerably decreased.

CHOICE OF CASES FOR OPERATION

Cromby,⁽¹⁵⁾ reviewing the international literature, comes to the conclusion that pneumothorax is applicable to only few children of all ages. He states further that anesthesia must be used and that the treatment is not devoid of dangers. A great obstacle to the successful production of pneumothorax is the adhesions which the use of the so-called oleothorax treatment may not always prevent or overcome. Because of the complications following pneumothorax, such as pleural shock, subcutaneous emphysema, and pleurisy with effusion, he believes that nature should be given a chance, supported by appropriate therapeutic hygiene.

No one denies that some cases will heal spontaneously, but such cases are not in the majority. It is in these cases that the mortality is high. The mortality with collapse therapy, not as a result of its use but in spite of it, is due to the far advanced stage of the disease when the treatment is instituted. Artificial pneumothorax is given to the hopelessly sick in an attempt to control the disease. Most men doing pneumothorax work in children say that it is a relatively safe method. It is the

surest means to prevent the spread of the disease. Of great importance is the early diagnosis of the lung conditions allowing the intervention before the lesions become diffused and extrapulmonary complications develop. When careful attention is given to the technic of the operation, few accidents are encountered such as air embolism, cardiac disturbances, pleural shock, and spontaneous pneumothorax. However as careful as one can be, one will occasionally meet with a spontaneous pneumothorax or subcutaneous emphysema, the latter of which can not be considered a serious complication. Desperate cases show at times unexpected improvement as shown by the clinical, roentgenographic and bacteriologic signs.

Zadez and Sonnenfeld⁽²⁰⁾ limited their cases to those having severe cavernous lesions, and consequently their series were small. They used a combination of pneumothorax and phrenic exeresis in four cases, one of which eventually came to thoracoplasty.

Perera Y Prats⁽²¹⁾ reported 17 cases of phrenicectomy in children between the ages of 7 and 14 years with excellent results.

Wolff⁽²²⁾ in discussing bilateral pneumothorax in children recommends its use in chronic ulcerated and caseous tuberculosis. No matter whether the disease is bilateral from the start, or becomes bilateral secondarily, or is extensive, it is the only treatment that can ameliorate prognosis. Untreated cases in such children are rapidly fatal, and should be treated in a sanatorium. The procedure is simple, and with a careful technic no accidents should occur. He concludes that in spite of the rather large portion of unfavorable cases the results obtained were very satisfactory.

Armand-Delille and his co-workers,^(19, 23, 24, 25) who have been doing compression therapy in children for the past 10 years, are very enthusiastic about the end results in these cases. Aside from getting very excellent results in the majority of their amenable cases, even in some of those of a hopeless nature, remarkable recoveries were observed. No accidents occurred in their series of cases, and a goodly percentage of them were satisfactory from every point of view, such as disappearance of the bacilli, regulation of temperature, decrease

in toxemia and regular increase in weight. Armand-Delille and his co-workers have also used bilateral artificial pneumothorax in children; and although the results were not as good as in the unilateral cases, nevertheless a cure was obtained in one-third of the cases. In these bilateral cases, life was prolonged even in the most hopeless cases. It is surprising how much collapse these cases can tolerate without the presence of dyspnea, as one-third of each lung can be compressed without apparent discomfort.

As regards their results observed in a group of 60 children from 1927-1930⁽²⁴⁾—43 unilateral and 17 with bilateral pneumothorax—34 of the 43 cases had tubercle bacilli, in 18 of which they have disappeared. Of the 17 bilateral open cases, 9 are now negative. There were 50 larger children of which 33 received unilateral treatment with good results in 32. Bilateral treatment was given to 17 cases (all of them being the older children) with 12 good results, 2 doubtful and 3 exacerbations. Of the remaining 10 small children receiving unilateral compression, a cure was obtained in four, a good result in five and a poor result in one.

CASES IN GLEN GARDNER

For the past three years a series of 27 cases have been treated by compression therapy at our sanatorium between the ages of five and one-half to fourteen. Those over fourteen years are usually admitted to the adult division. Two cases were minimal with symptoms and signs; 8 were moderately advanced; and 17 were far advanced. In the beginning, considerable doubt was anticipated as to the value of such procedures because of the hopelessness of the disease present. Having learned for the past many years that the majority died, we felt that something should be done for them. Consequently all types and stages were treated either by phrenicectomy, or pneumothorax, or a combination of both. Whether we expected any good or bad results was beside the point, for we felt that something beside the routine sanatorium care as to strict bed rest, high vitamin diet, etc., should be attempted. We were surprised, as we went along, to find the

reduction of the mortality and morbidity, the lowering of the fever and toxemia, and the arrest of the disease in some of hopeless expectation.

Four patients in the far advanced stage died, one within a month after admission, one within five months, another six months later, and a fourth within three years. All of these were considered hopeless. Of the remaining more or less hopeless cases some made remarkable recoveries. Over 80 per cent had cavities. The best results were obtained in the early cases including the moderately advanced; and in 50 per cent of the far advanced patients the results were very satisfactory and gratifying. Nineteen patients had positive sputum on admission, and of these 60 per cent have been negative for a period of six months to two years.

Artificial pneumothorax was initiated in 18 cases; and in two of these interruption or crushing of the phrenic nerve was done before, and in three others after the use of pneumothorax. Excellent results were obtained in 11 patients. In one case artificial pneumothorax was given when the child developed a pleurisy with effusion with marked dyspnoea, great toxemia, fever of 104° F. and a loss in weight. Removal of the fluid with replacement by air promptly brought down the fever with amelioration of all symptoms in a short time. One patient received bilateral pneumothorax from the start; and in another the contralateral lung was collapsed after a spread to that side. The former case is hopeless and the latter temporarily satisfactory. Another bilateral case received pneumothorax for a period of 10 months on the worst side, and then the contralateral lung was compressed with very good results.

In seven cases phrenic exeresis or crushing alone was performed, with excellent results in two and satisfactory in one while seven died as mentioned before. In one case artificial pneumothorax could not be given because of the adherence of the lung to the pleura, and a temporary phrenic crushing was performed. In another case crushing of the phrenic nerve was resorted to because no free pleural space could be found and a cavity was seen at the base.

This child had very little expectoration being persistently negative for tubercle bacilli. When a temporary crushing was resorted to, the cavity was tilted and a profuse foul expectoration was obtained, being again negative to tubercle bacilli but positive with the Klieve stain for fuso-spirochetal organisms. A *lung abscess* had been suspected all along, but the history was very vague.

Effusions after the induction of artificial pneumothorax were seen in four cases, being minimal in three and moderate in one. Mediastinal hernia was present in four patients; and it is surprising how much the mediastinum can be displaced without any outward signs. Naturally, less refills are to be given to such patients. Subcutaneous emphysema was seen in only one case, but the air was absorbed within a few days. The most annoying hinderance to the successful collapse of the lung is adhesions. However, some of these can be overcome by frequent small refills or the addition of a phrenic crushing which temporarily paralyzes the diaphragm and helps to collapse the diseased lung.

During the entire period of three years of comparison we have encountered no accidents. No general anesthetic or hypnotic was necessary prior to the initiation of artificial pneumothorax. It is very gratifying to see these children take their treatments very unconcernedly after we have explained to them what they have to expect and what they will experience. If we see a child being fearful, we allow that child to witness an operation. Seeing very little disturbances on the part of the other child, the second patient in turn will try to outdo his neighbor as far as behavior is concerned. This method of ours has failed in only one case. This child six years old was mentally deficient and had had his initial treatment in another hospital and had been sent to us for its continuation.

The treatments as observed here have no influence on the mental or physical development of the children receiving therapeutic compression. They gain in weight in proportion to the removal of the toxemia; and they gain in height and mental alertness. No deformity of the chest has been observed.

CASE REPORTS

It will be noteworthy now to briefly cite a few of our cases treated at the sanatorium. The results so far have been gratifying in the majority of our cases. Disappointments have

been encountered as anticipated, but on the whole we feel very much encouraged with the work. Both types of cases will, therefore, be shown.

CASE I.

Case I. C. L., a colored boy, 12 years old, admitted on December 1930, with a history of being exposed to a tuberculous uncle in 1926. On entrance he showed a few discharging cervical glands, a fever of 99 to 102° F, and very few physical findings in the left upper chest. X-ray on Dec. 5, 1930 (fig. 1), shows mottling in both apices with greater accentuation in the left subclavicular region. Note the calcification of the cervical glands. He was put on routine rest cure with high caloric and vitamin diet and ultra-violet exposure to the enlarged glands. The swellings subsided in most of the glands but the sinus persisted in one in spite

ranged between 99 to 100° F. Further examination revealed signs of cavitation in the upper left sub-clavicular region.



Case I., Fig. 1—Dec. 3, 1930. Mottling of both apices.

of the treatments. His fever disappeared and he was allowed to be up under supervision. At no time was there a positive tubercle bacilli obtained from the glandular sinus or sputum.

This condition remained quiescent until March 1932, when one of the left posterior cervical glands became progressively enlarged and began to show fluctuation. He began to exhibit a fever of 99 to 101° F. This gland was incised on March 4, and two days later the patient complained of severe pain on breathing in the left side with cough, slight expectoration, a fever of 104° and a pulse of 136. Physical examination revealed a consolidation of left upper lobe, probably a tuberculous pneumonia as shown in fig. 2. Sputum was persistently negative for tubercle bacilli; and within 20 days most of the symptoms had subsided but the temperature



Case I., Fig. 2—March 6, 1932. Tuberculous consolidation of left upper lobe.

A roentgenogram on April 17, (fig. 3), shows considerable absorption at the pneumonic area but there is a cavity measuring 2½ by 2½ cms. under the left clavicle.

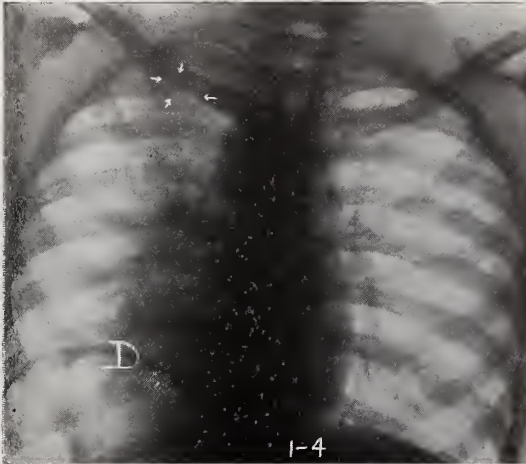


Case I., Fig. 3 April 17, 1932. Cavity in former pneumonic area.

A phrenic exeresis was performed on the left side on May 31, 1932. Recovery was gradual as the toxemia and physical signs began to diminish. An x-ray within a month (fig. 4) showed the cavity much smaller ($1\frac{1}{2}$ by $1\frac{1}{2}$ cms. with a rise of 4.5 cms. in the diaphragm. There was complete disappearance of all signs and symptoms about Aug. 1932 and he was allowed to be up and about.

Left

Right

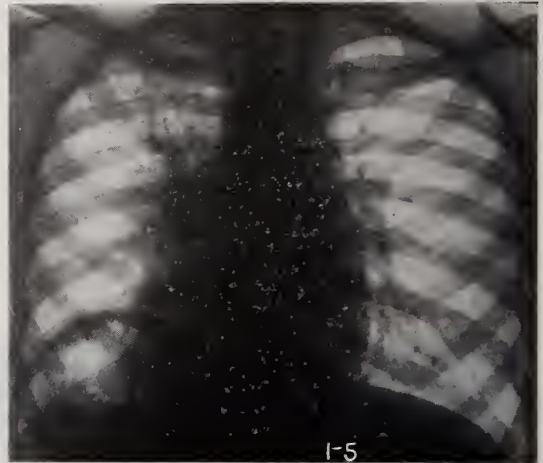


Case I., Fig. 4—June 30, 1932. Cavity decreasing after an exeresis of the left phrenic nerve done May 31, 1932. Note the rise of the diaphragm, D, on the left side.

Dec. 13, 1932 (fig. 5) the cavity is closed and there is evidence of considerable fibrosis. He was soon discharged to his home with a gain of $14\frac{1}{2}$ lbs in weight. We have subsequently heard from his physician (16 months later), and the patient is said to be in excellent condition. His cervical adenitis has completely disappeared under roentgen exposures.

Left

Right



Case I., Fig. 5—Dec. 13, 1932. Cavity closed and replaced by considerable fibrosis.

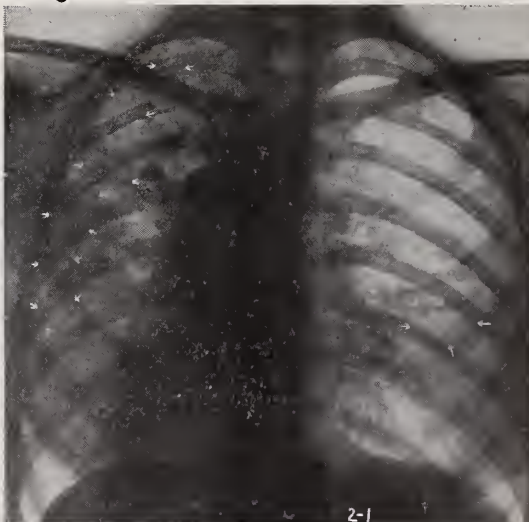
CASE II.

Case II. R. F., a white girl, 13 years old, admitted on Sept. 17, 1930, with all the classical symptoms and signs of an active far advanced tuberculosis,

with strongly positive sputum. There was no history of tuberculosis in the family, and no known exposure. X-ray on admission (fig. 1), shows mul-

Left

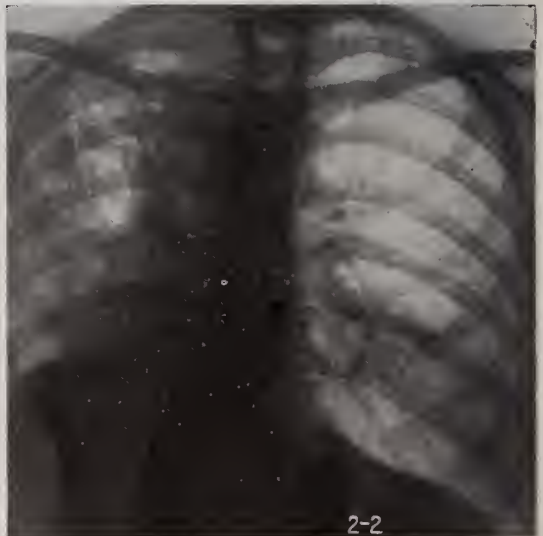
Right



Case II., Fig. 1—Sept. 17, 1930. Multiple cavitations throughout the entire left lung. Mottling of the right apex. Cavity in fourth interspace of right mid-lung.

Left

Right



Case II., Fig. 2—Sept. 22, 1931. Rise of left diaphragm of 5 c.m. after an exeresis done on Sept. 15, 1931.

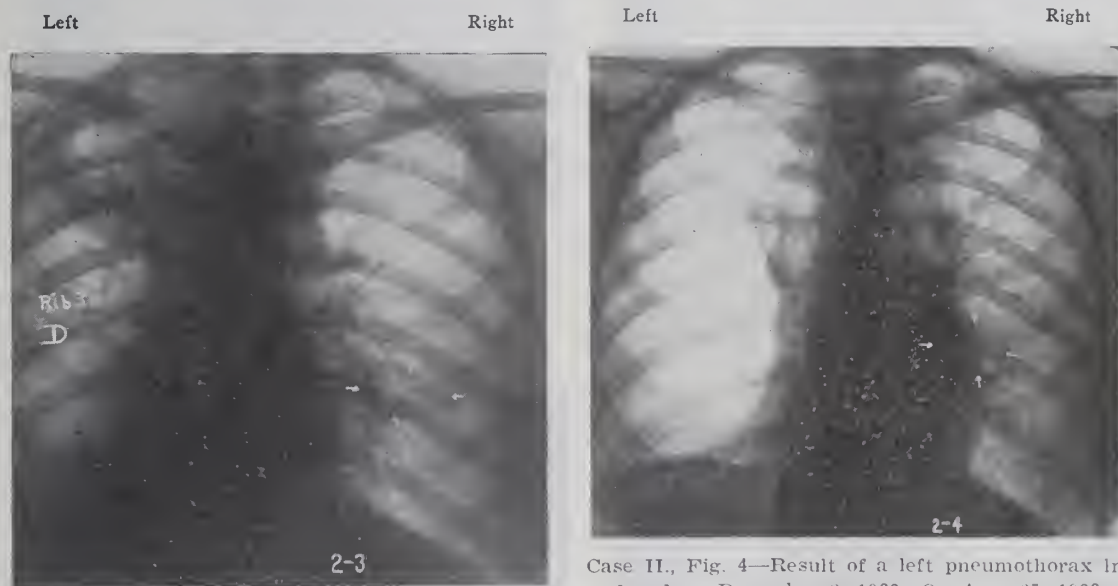
tiple cavitation throughout the entire left lung; mottling in the right apex, and a cavity in the 4th interspace in the mid-lung region.

The routine sanatorium care was adopted. While being on absolute bed rest her toxemia gradually subsided as evidenced by a normal temperature and some gain in weight, but the sputum was persistently positive. Evidently her general condition was hopeless; and as strict regime was not sufficient we thought that a phrenic exeresis might help.

The operation was done on Sept. 15, 1931, on the left side and an x-ray (fig. 2) one week later showed a rise of the diaphragm of about 5 cms. The improvement continued and the sputum became negative on Nov. 9, 1931, and remained so until July 21, 1932. Examination revealed progressive cavitation, and a roentgenogram (fig. 3) now exhibited a marked rise of the diaphragm to the third rib and progressive upper cavitation. The one on the right showed slight progression. It was now felt that the paralysis of the diaphragm

was not doing any good and pneumothorax was induced on the left side on Dec. 2, 1932. Her sputum promptly became negative again and remained so until her discharge from the institution.

An x-ray on Aug. 25, 1933 (fig. 4), shows a 90 per cent collapse, a moderate mediastinal displacement of the right, and an apparent quiescence of the cavity on the right. It was felt that since the cavity on the right, although showing a sputum level, did not give any trouble, it was best to let it alone and later allow some reëxpansion of the left lung so that pneumothorax could be induced on the right. The patient had reached the maximum residence here and she was discharged to another hospital for further maintenance of her artificial pneumothorax. While here she was symptomless and had gained 32 lbs. We have recently heard from the patient (9 months later) and find her in apparently good shape. The outlook of the patient was hopeless at the start, but the compression therapy has kept her alive for about three years and she may, perhaps, yet get well.



Case II., Fig. 3—July 21, 1932. Cavitation on the upper side is progressing. The cavity on the right is slightly larger. The left diaphragm has risen to the third rib anteriorly.

Case II., Fig. 4—Result of a left pneumothorax induced on December 2, 1932. On Aug. 25, 1933, 90 per cent collapse of left lung. Moderate mediastinal displacement toward the right side. Right cavity apparently quiescent.

CASE III.

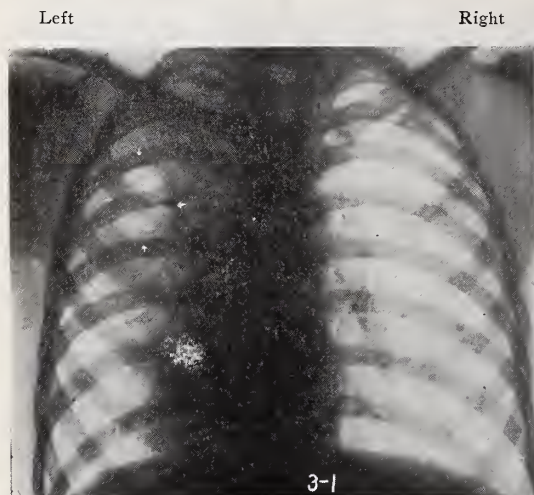
Case III. E. McG., a white girl, 9 years. was admitted to the sanatorium on Sept. 9, 1932, with a story of being well until two years before her admission, when she was in an automobile accident, sustaining a fractured skull and internal injuries. She was removed to a local hospital unconscious and regained consciousness after a few hours. She remained in the hospital three months. Following her discharge from the hospital she was complaining of weakness, cough, expectoration, and night sweats. She began to lose weight and had a severe pain in the left side of her chest. She remained at home for almost two years until finally her father

took her for an examination to the local tuberculosis clinic.

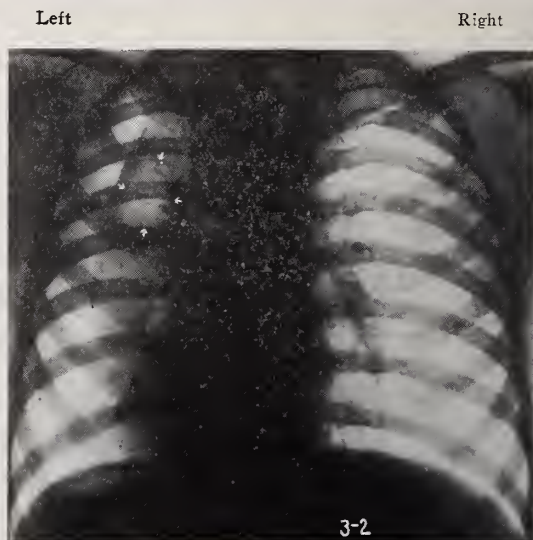
There was no history of exposure to tuberculosis. A roentgenogram on admission (fig. 1) revealed considerable mottling in the first and second interspaces on the right. Note the Ghon tubercle (calcified primary lesion) under the seventh rib. On the left we see extensive tuberculous involvement of the entire upper lobe with a cavity 4 by 2½ cms. The sputum was strongly positive, and the temperature was between 99 to 101° F. Pneumothorax was induced within a week and x-ray on Sept. 19, 1932 (fig. 2), shows the cavity reduced in size (3 by 2

cms.), with the contralateral lung quiescent. Five months later (fig. 3) shows the cavity much smaller ($2 \times 1\frac{1}{2}$ cms.) with some clearing of the other side. The mediastinum was found to be very freely movable with some displacement to the right. Fifteen months later (fig. 4) the cavity was less than a half a centimeter open and the right side has completely cleared. However, there was moderate mediastinal displacement, and as a result the pneumothorax could not be forced any further so as to close the cavity completely.

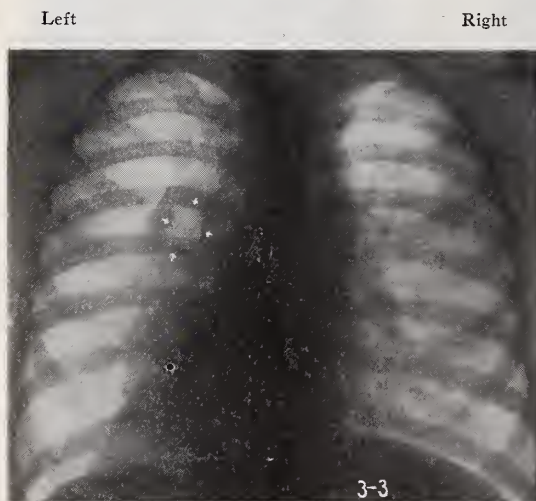
The sputum became negative on May 19, 1933, and has remained so for the past eleven months. She is on 20 minutes exercise, has gained 4 inches in height and 28 lbs. in weight. Due to the excellent condition of the patient and the persistent negative sputum, we hesitated to induce an oleothorax to produce fluid so that the mediastinum could be made rigid. However, we have done so recently and the cavity is closed.



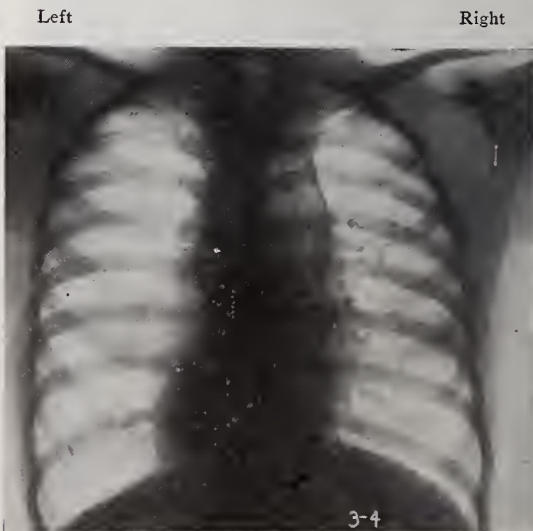
Case III., Fig. 1—Sept. 9, 1932. Mottling in right 1st and 2nd interspaces. A Ghon tubercle (calcified primary lesion) under fourth right rib. Left side involvement of entire upper lobe, with a cavity.



Case III., Fig. 2—Result of left pneumothorax induced on Sept. 17, 1932. Sept. 19, 1932, left cavity smaller. Pneumothorax 40 per cent. Right side quiescent.



Case III., Fig. 3—Cavity still smaller, and some clearing has occurred in the right lung.



Case III, Fig. 4—Dec. 29, 1933. Cavity nearly closed. Moderate mediastinal displacement to the right.

CASE IV.

Case IV. M. G., a white girl, 14 years, admitted on Sept. 29, 1933, with a history of being exposed to a tuberculous mother who died in April, 1931. One year before her mother's death the patient had

"pneumonia" on the right side, being confined to bed for a few months. She had been coughing on and off until two months before entrance, when the cough became very persistent with progressive loss

in weight though she was above normal weight. Examination revealed suspicious signs of cavitation in the right lower lobe but her sputum was negative.

within two weeks. Her expectoration markedly increased for the first few days, and positive sputum was obtained. A roentgenogram on Nov. 9, 1933 (fig. 3), shows a selective collapse of the lower lobe



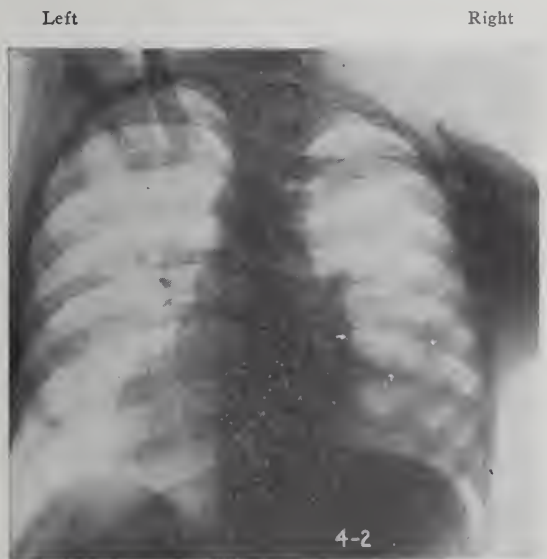
Case IV., Fig. 1—Oct. 3, 1933. Right side, large cavity near base. Left side, an early sub-apical infiltrative lesion.

An x-ray on October 3, 1933 (fig. 1), showed an early infiltrative lesion in the left subclavicular region. On the right side was seen a cavity meas-



Case IV., Fig. 3—Result of a pneumothorax induced on Oct. 17, 1933. Nov. 9, 1933, right lower lobe, selective collapse. Contralateral lesion quiescent.

with almost complete collapse of the cavity. The lesion in the left apex remained quiescent. Her sputum became negative Nov. 17, 1933, and at no



Case IV., Fig. 2—Oct. 3. An oblique view shows conditions as in Fig. 1, but more clearly.

uring 4 by 3 cms., surrounded by an inflammatory infiltrative lesion extending to the base. An oblique view was taken (fig. 2) which exhibited the cavity much more clearly. Pneumothorax was started



Case IV., Fig. 4—Feb. 22, 1934. Complete collapse of right cavity under a 50 per cent lung collapse; and a 90 per cent selective lower lobe collapse.

time did the temperature rise above 99° F. A recent x-ray, Feb. 22, 1934 (fig. 4), reveals complete collapse of the cavity under a 50 per cent collapse of the lung. Note also the clear outline of the

three lobes. Her sputum has now been negative for seven months, she has gained 14½ lbs. and is on 20 minutes exercise and does not expectorate.

CASE V.

Case V. D. A., a white girl, 13 years, admitted May 9, 1932, was a positive contact case, her father and a brother having died of tuberculosis. She had been in apparently in good health until Aug., 1931, when she had a slight cough with scant expectoration. Jan., 1932, she suddenly had a hemorrhage and within three days raised about a quart of blood. She was immediately removed to the hospital, where she complained of pain in the chest and night sweats, and her sputum was negative.

An x-ray revealed generalized increased markings throughout both lung fields. At the level of the second rib was an annular shadow surrounded by tuberculous infiltration. Pneumothorax was immediately given. On entrance the x-ray plate

revealed a 30 per cent pneumothorax space on the right, with adhesions holding the upper lobe to the chest wall. The cavity was practically closed while the rest of the lung fields were clear. No fever was present nor was there at any time positive sputum. Pneumothorax refills were given and she continued to be in good condition.

An x-ray on Dec. 5, 1933, shows a 60 per cent collapse, a total disappearance of the cavity and the upper lobe held to the chest wall by a dense broad adhesion. She was discharged home on Dec. 19, 1933, with the recommendation that pneumothorax be discontinued and the lung allowed to expand slowly. At the end of her stay she was in excellent shape, being on 30 minutes exercise and gaining 17 lbs.

COMMENT

The eradication of tuberculosis in its final analysis will depend upon the eradication of tubercle bacilli. Present opinion is that the small healed lesions of the so-called childhood infection do not produce an adequate immunization, but on the contrary, probably due to a hyperallergic reaction, they increase the intensity to the disease. It is not always easy to differentiate the initial infection from the second infection. Compression therapy is, we believe, the best aid at present in preventing either pulmonary or metastatic spread or infection of the associated tissues.

The diagnosis of tuberculosis in children in the absence of tubercle bacilli often taxes all our ingenuity and at times it cannot be made until all means possible have been exhausted. None of us, however skilled, can always diagnose tuberculosis without tuberculin, even though the x-ray is available. So far, the earliest deductions of Rathburn⁽¹¹⁾ are accepted—that the 3 or 4 per cent of early infections finally furnish 75 per cent of adult disease. If this is so, the disease will be finally banished in proportion as we eradicate tubercle bacilli. Compression therapy will eradicate the bacilli in 80-90 per cent of all cases where efficient compression can be secured. If all the cases are considered, including all stages of collapse, disappearance of bacilli approximating 60-70 per

cent can be secured. When we consider that the ordinary sanatorium or so-called hygienic-dietetic treatment in the most favorable open cases bring about but 10 per cent of negative sputum in the usual sanatorium residence, the benefits of the compression are evident.

SUMMARY

1. The importance of the tuberculin test in children cannot be too strongly emphasized in the detection of adult disease in children who harbor no complaints.

2. The frequent use of x-ray in the strongly positive tuberculin cases for the detection of pulmonary involvement in children is of vital importance, especially in those that physical signs cannot be detected.

3. Early detection of the disease in children should be secured so that early institution of treatment can be given.

4. Rest and routine sanatorium hygienic-dietetic treatment is not sufficient for the treatment of adult disease especially in those having active processes.

5. Artificial pneumothorax should be instituted as early as possible. This type of treatment should be preferred to other forms of compression therapy. Phrenic exeresis or temporary interruption should be performed only in selected cases, and only as an aid to pneumothorax if for any reason the latter can-

not be given. It should be used if an adhesive pleurisy is present or as an aid when the compression by pneumothorax is insufficient because of adhesions. The mere absence of tubercle bacilli in the sputum should not deter one from going ahead with collapse therapy when pulmonary pathology is present in the chest. Artificial pneumothorax was successful in 60 per cent of our cases.

6. The results with phrenic interruption were disappointing; but one must consider the fact that many of the cases were hopeless, while in others it was used when pneumothorax could not be given.

7. Therapeutic compression was responsible for the reduction of our positive sputum cases to negative in 60 per cent of the cases. It is also directly responsible for the reduction of symptoms, cough, and expectoration in the majority of the cases. These disappear in direct proportion to the successful compression of the diseased area. Patients with far advanced disease should not be deprived of this form of therapy, since highly satisfactory results were obtained in over 50 per cent of them.

8. Most authors stress the harmlessness of these procedures in children. No serious accidents were encountered and no complications, retardation, or physical defects occurred.

9. The amount of compression in artificial pneumothorax should be used to an optimum degree and not a maximum. Our aim in children with such a procedure is to compress the diseased area only, whether it be a cavity or a pneumonic process. If we can succeed with a 30 per cent collapse, it is sufficient to maintain that pressure and not to make it a 100 per cent.

10. Although our series of cases are small, nevertheless we cannot help being enthusiastic judging from the results obtained. The observation of these children has only been of a short duration (from 6 months to 3 years), yet the present states of these cases are highly encouraging. The future outcome of these cases can only be determined within the next few years as to the effectiveness of compression therapy. However, the present results make us very optimistic as to the value of such measures.

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SUPPURATIVE HIP IN CHILDREN

By G. HERBERT TAYLOR, M.D., East Orange, N. J.

From the Orthopedic Service, Orange Memorial Hospital, Orange, N. J. Read before the Section on Radiology at the Annual Meeting of the Medical Society of New Jersey on June 6, 1934, in Atlantic City

It is a fact that suppurative arthritis of the hip in children can be fatal to joint function unless a diagnosis is made early enough to relieve intra-articular pressure and to establish free drainage.

While the etiology may be attributed to direct trauma or direct extension from neighboring infection, the causative factor in many cases is blood borne and often follows in the wake of some minor upper respiratory tract infection.

The usual symptomatology shows a general toxemia with increasingly high temperature and leucocytosis, plus the local symptoms. These are, first, pain referred to the hip, followed rapidly, as a rule, by muscle spasm, protective position of flexion with local inflammatory signs and loss of the gluteal fold.

At this point the aid of the roentgenologist is usually sought and because his report frequently comes back "no evidence of pathology", valuable time is lost waiting for the pathology to develop. When "pathology" can be detected in the film, the clinical symptoms will long since have demanded surgical interference. The roentgenological examination should include both hips on one film made at the same exposure. This may avoid errors arising from difference in density of the shadow. A careful study will often reveal a widening of the joint space, a distended capsule, but nothing else. There is apt to be considerable discussion of radiolucent areas in the femoral neck and head, but these must be evaluated only in conjunction with the clinical findings.

However, widening of the joint space, with the local symptoms enumerated above, should suggest the use of the aspirating needle. With aseptic technic a 16-gauge needle should be carefully used to explore in a search for fluid under pressure or perhaps pus. The presence of fluid under pressure quickly exerts a destructive action upon the joint cartilage. Therefore, early drainage is demanded if we wish

to save function in the joint. Spontaneous subsidence of proved suppurative arthritis of the hip can occur but usually is accompanied by destruction of the femoral head and neck.

In draining the hip, while the anterior route is claimed to be anatomically correct and also the easier, I have always used the posterior—perhaps from familiarity with this procedure. The muscles of the buttock can be separated with little hemorrhage, but the contraction of their fibers frequently make a rubber tube drain necessary. The joint space may be irrigated with saline. In one case with a favorable outcome, a bacteriophage was used with apparent success. While the capsule must be opened freely if drainage is to continue, care must be taken to prevent dislocation of the femoral head by a too generous incision—an accident which occurred in one of the cases reported.

During the early stages of the infection, the child as a rule is made more comfortable by light extension to the affected extremity. To prevent subsequent deformity, a light plaster spica will not only be indicated but will make the nursing care easier and facilitate the handling of the child. In the use of plaster in a drainage case, care must be exercised to prevent the discharge from seeping under the jacket as a dermatitis will quickly follow. Wide trimming of the plaster about the drainage area—with the edges waterproofed with shellac—will prevent accidents from this source.

With the subsidence of the infection, efforts must not be spared to prevent deformity. It has been demonstrated that the application of plaster alone without traction—while preventing flexion and lateral deformity—will not necessarily prevent further destruction of the femoral head. These cases frequently need traction until a regeneration of the structures about the hip joint has taken place. Weight bearing is not to be considered until we are assured of a hip joint free from active disease.

Recurrences are not uncommon. Cases that

have stopped draining—the sinus healed and the hip free of symptoms—will very often show a return of pain, muscle spasm, and other local symptoms. These secondary attacks may appear spontaneously or accompany again a tonsilitis or upper respiratory tract infection. And, therefore, we must in every case attempt by thorough physical and laboratory examination to find if possible the primary focus.

Examination of the aspirated fluid will show most frequently streptococcus, staphylococcus, or pneumococcus. That these may also be found on blood culture does not necessarily mean that the organism is growing in the blood stream.

The treatment should, of course, be based on careful symptomatic study. While drainage of the abscess cavity is of primary importance, intravenous saline and transfusions have been used with unquestionable benefit to combat the toxemia. The use of bacteriophage is recommended when proper laboratory supervision is at hand. The writer believes that one rather desperate case received definite help from this direction.

The following cases are presented to show some of the individual characteristics met with in this condition:

Case 1. A boy $2\frac{1}{2}$ years of age. Three weeks before admission to the hospital had had a nasal infection with a profuse discharge. This was followed by a rising temperature, anorexia, irritability, vomiting, chills and fever. Three days before admission, the right hip began to contract. The boy had night sweats and severe pain in the hip. Upon admission, he had a temperature of 105 degrees; he looked toxic; heart and lungs were normal; no adenopathy; pharynx was clear. The urine was negative; Widal negative; Mantoux negative; throat culture negative. Blood culture negative: 4,000,000 reds; 14,600 whites with 62 per cent polys. The boy was seen by the writer the day after admission. X-rays had been taken and showed distention of the capsule. The hip was aspirated, pus was found, and immediate incision and drainage was established. Drainage continued for 21 days. The infecting organism was staphylococcus. The sinus healed and the boy went on to complete recovery. It is now 9 months post-operative and the child walks normally, has no limitation of motion, and no local symptoms.

Case 2. A girl 9 years of age. Admitted to Essex County Isolation Hospital with a diagnosis of facial erysipelas. The child was acutely ill and toxic with a temperature of 105 degrees, and their diagnosis

was cavernous sinus thrombosis and staphylococcus septicemia. The abscess was localized in the frontal region. Immediate incision and drainage of the frontal abscess and staphylococcus was obtained on culture. The child was desperately sick, had numerous transfusions, and intravenous bacteriophage. After a stormy convalescence, she was discharged to her home on October 7th. This case showed a blood culture of staphylococcus. On admission her white cell count was 11,700 with 79 per cent polys; 2 days later 18,000 with 76 per cent polys; 2 weeks later 11,500 with 80 per cent polys. Blood culture consistently showed staphylococcus. After being home 2 weeks the child was admitted to Orange Memorial Hospital with symptoms of acute epiphyseitis of the right hip.



Case 2, Fig. 1—Suppurative right hip, Oct. 21, 1933, with widening of joint space.

She was seen by the writer and aspiration showed pus and the hip was immediately opened and drained. Staphylococcus pus was removed. A slow convalescence ensued and it was 3 months later before the drainage ceased. She went home the last of January, had a slight recurrence of pain and spasm in the hip in February, since when she has been without symptoms except slight limitation of motion in the hip.



Case 2, Fig. 2—Twelve weeks later. Abscess healed. Reconstruction period.

This case is interesting because while at the Isolation Hospital her condition was considered critical and a staphylococcus bacteriophage in broth was used locally and an asparagin bacteriophage was used intravenously as a last resort. Startling improvement followed the use of this bacteriophage. Therefore when the child came to Orange Memorial Hospital the use of this bacteriophage which had been prepared at the New York Post-Graduate Hospital laboratory was continued.

Case 3. A boy 7 years of age. Three weeks before admission he had a severe adenitis with increasing temperature and toxemia. He was seen by the writer 4 days after admission when the symptoms had localized in the left hip. The urine showed a low specific gravity, blood, pus, and

followed by arthrotomy and the x-ray taken the next day showed that the hip had dislocated posteriorly. The hip was reduced and the child was put up in double plaster spica. At the present time—4 months after her tonsillectomy—she is in



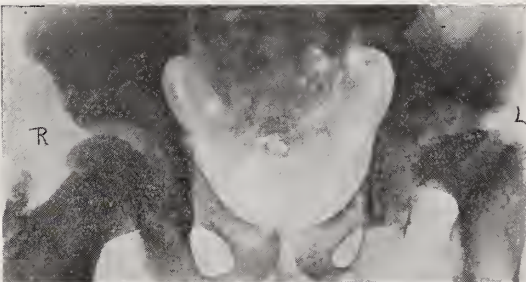
Case 3, Fig. 1—Abscess left hip; day of operation.

acetone. Blood showed 3,800,000 reds, 80 per cent Hb, 17,200 whites with 84 per cent polys. Wassermann and Kahn tests negative. Blood culture showed no growth. The hip was immediately aspirated, pus was found, and free drainage was established. This pus showed a hemolytic streptococcus the same day this organism was obtained on blood culture. Four days later the right hip



Case 4, Fig. 1—Abscess left hip, showing distended capsule; day of operation.

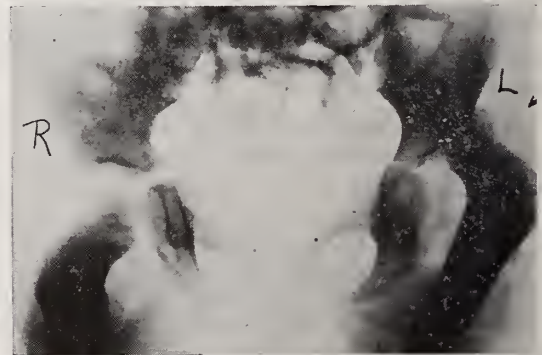
a double plaster spica and the hip is still draining. The organism in this case was streptococcus. Blood cultures were consistently negative and while the child is convalescing, I believe that it will be too optimistic to expect motion in this hip.



Case 3, Fig. 2—One year later, showing extensive destruction.

and left forearm showed abscess formation and were drained. After a stormy convalescence in which numerous blood transfusions were used, the child was sent home 8 weeks after admission with the left hip still draining and a traction hip splint applied. Progressive destruction has continued in this hip until the epiphysis is completely gone and the neck badly eroded. The boy is still doing no weight bearing on the hip and will continue to wear a traction hip splint.

Case 4. A girl 4 years of age. Admitted to Orange Memorial Hospital for a tonsillectomy. Her previous illness had consisted of a mastoidectomy at the age of 4 months. Her father has tuberculosis. Her history is otherwise negative. Eighteen hours after the tonsillectomy, her temperature rose to 105 degrees and a general toxemia rapidly developed. She was referred to the orthopedic department 8 days later when the symptoms had localized in the left hip. X-rays showed widening of the joint space. The hip was aspirated; this was



Case 4, Fig. 2—Two weeks later, showing dislocation of femoral head.

SUMMARY

1. Acute suppurative arthritis of the hip in children frequently follows acute upper respiratory tract infections, as well as direct trauma or infection from neighboring focus.
2. Early diagnosis is essential to ultimate joint function.
3. Early x-ray findings must be interpreted only in conjunction with local clinical symptoms.
4. Presence of pus in joint cavity demands immediate and free drainage.
5. Prevention of deformity and protection of the hip joint are essential to future joint function.

LESIONS OF THE ORAL MUCOSAE

By JOSEPH JORDAN ELLER, M.D., and CHARLES ROBERT REIN, M.D., New York

Read before Dental Section of the Newark Academy of Medicine, Newark, N. J., October 6, 1932.

The mouth is the most contaminated cavity in the body and the offending organisms which are present from birth are often of a highly pathogenic nature. Various bacteria are inoculated upon the oral mucosa of the suckling infant and of the bottle-fed baby. The dangers of infection are increased with the onset of the first dentition. It is not uncommon for teething infants to develop convulsions because of toxic absorption from oral sepsis. The great number of local and generalized infectious processes arising from oral sepsis is well known and renders oral hygiene a major medical and dental problem. Oral lesions are sometimes the first and only manifestation of a generalized infection. Embryologically, the skin and oral mucosa are derived from a common ectodermic origin. Therefore, one can

expect to find oral lesions in patients with certain dermatoses.

Lesions of the oral mucosa are, however, often difficult to diagnose on first examination because they are somewhat modified by such additional factors as moisture, heat, traumatism, and bacteria which are always present in the mouth. Therefore, one should not expect the dentist to make a definite diagnosis, but rather to determine the presence of a pathologic oral condition. He should be sufficiently capable in diagnosis, however, to be able to determine whether the oral lesions are within his realm of practice; and if not, he will direct such patients to experts for early diagnosis and judicious therapy.

Mouth lesions are of very great variety, but the following classification will be helpful to the physician and oral surgeon:

CLASSIFICATION OF MOUTH LESIONS

I. SYSTEMIC DISEASES WHICH MAY BE ANTEDATED BY MOUTH LESIONS

- a. Exanthems
 1. Measles—Koplik spots
 2. Scarletina—Pharyngeal congestion
 3. Variola—Maculo-papular
 4. Varicella—Vesicles appear as modified spots
- b. Pemphigus
- c. Pernicious anemia
- d. Leukemia
- e. Addison's disease
- f. Lichen planus
- g. Erythema multiforme
- h. Mucosis fungoides
- i. Carcinoma of suprarenal with atrophy of lingual papillae
- j. Dermatitis herpetiformis
- k. Agranulocytic angina
- l. Polycythemia
- m. Jaundice (bleeding gums)
- n. Hypertrophia cirrhosis

II. ORAL LESIONS DUE TO THE INGESTION AND ABSORPTION OF VARIOUS DRUGS

- a. Mercury
- b. Bismuth
- c. Arsphenamine
- d. Antipyrin group
 1. Antipyrin
 2. Acetanilid
 3. Phenacetin
 4. Pyramidon
- e. Barbitol group
- f. Salicylates
- g. Phenolphthalein
- h. Bromides
 1. Iodides
 2. Silver-nitrate of silver, argyrol
 3. Lead
 4. Copper
 5. Gold
 6. Radium (bone necrosis)

III. ORAL LESIONS AMONG WORKERS IN CHEMICALS

- a. Mincrai acid fumes
- b. Lead
- c. Copper
- d. Mercury
- e. Chlorine
- f. Phosphorus

IV. ORAL LESIONS IN SPECIFIC DISEASES WITH CHRONIC INFECTIOUS GRANULOMA

- a. Syphilis
 1. Primary stage (chancre)
 2. Secondary stage (mucous patches)
 3. Tertiary stage (gumma, glossitis, leukoplakia)
- b. Tuberculosis
 1. Lupus vulgaris
 2. Lupus miliaris
 3. Tuberculosis of oral cavity secondary to pulmonary tuberculosis
 4. Sarcoid
 5. Lupus erythematosus
- c. Leprosy
- d. Yaws
- e. Gangosa
- f. Glanders
- g. Rhinoscleroma
- h. Actinomycosis

V. YEAST INFECTIONS

- a. Thrush
 1. Monilia albicans
 2. Monilia candida
 3. Monilia pinoyi
- b. Macroglossia mycetozoa
 1. Monilia macroglossia castellani
 2. Monilia aldrichi
- c. Blastomycosis

VI. SKIN LESIONS EXTENDING INTO ORAL CAVITY

- a. Cheilitis exfoliativa
- b. Psoriasis
- c. Fordyce disease
- d. Perleche
- e. Eczema

VII. ORAL LESIONS WHICH ARE OFTEN ASSOCIATED WITH
GENITAL LESIONS

- a. Pemphigus
- b. Pellagra
- c. Lichen planus
- d. Herpes
- e. Vincent's infection
- f. Periadentitis mucosa necrotica recurrens

VIII. ORAL LESIONS ASSOCIATED WITH MENSTRUATION

- a. Vicarious menstruation
- b. Aphthous stomatitis
- c. Menstrual herpes
- d. Erosion of lips at menstruation
- e. Exacerbation of any present mouth lesions

IX. LESIONS INCIDENT TO PREGNANCY

- a. Gingivitis gravidarum
- b. Benign new growths (epulides)
- c. Transitory benign plaques

X. DISEASES OF TONGUE

- a. Moeller's glossitis
- b. Lingua geographica (erythema migrans)

XI. CONGENITAL LESIONS

- a. Epidermolysis bullosa hereditaria
- b. Ichthyosis
- c. Black hairy tongue
- d. Lingua plicata (scrotal tongue)

XII. CYSTS OF MOUTH

- a. Labial
- b. Mucous
- c. Salivary, parotid, lingual
- d. Cysts about teeth
 - 1. Dental cyst
 - 2. Follicular odontoma
 - 3. Epithelial odontoma
- e. Myeloma
- f. Cysts of antrum

I. ORAL LESIONS WHICH MAY ANTEDATE
SYSTEMIC DISEASES

Many serious and fatal systemic diseases present their first visible evidence in the mouth. The dentist, therefore, is often the first to be consulted by patients with oral manifestations of such diseases as pemphigus, lichen planus, pernicious anemia, agranulocytic angina and leukemia. M. H. Feldman recently reported a case of acute myeloblastic leukemia with oral lesions. Pemphigus, which is a fatal systemic disease with skin manifestations, usually begins on the lips or in the mouth.

J. Schroff reports that 50 per cent of the patients with pemphigus have *primary* lesions in the mouth.

II. ORAL LESIONS DUE TO THE INGESTION
AND ABSORPTION OF VARIOUS DRUGS

Many drugs may give rise to mouth lesions in sensitized individuals. The commonest drugs are mercury, bismuth, and arsphenamine, which are used in the treatment of syphilis. Others are the antipyrin group, the barbitol group, the salicylates and the halogen

- g. Ranula
- h. Salivary calculus (Wharton's duct)
- i. Dermoid cysts
- j. Parasitic cysts
- k. Thyroglossal (duct cyst)
- l. Blood cysts—hemorrhage

XIII. PRECANCEROUS MOUTH LESIONS

- a. Syphilis
- b. Non-syphilitic leukoplakia
- c. Papilloma
- d. Tuberculosis
 - 1. Lupus vulgaris
 - 2. Tuberculosis verrucosa cutis
 - 3. Lupus erythematosus
- e. Blastomycosis
- f. Chronic ulcers and fistulous tracts
- g. Pellagrous ulcers
- h. Lichen planus—rarely

XIV. BENIGN TUMORS

- a. Fibroma keloids
- b. Lipoma
- c. Myoma (rare)
- d. Osteoma
- e. Myxoma
- f. Angioma
- g. Benign giant cell tumor
- h. Epulis

XV. MALIGNANT TUMORS

- a. Carcinoma
 - 1. Papilloma
 - 2. Adenoma
 - 3. Carcinoma—all prickle cell except those extending into mucous membrane from glabrous skin
 - 4. Transitional cell, epidermoid carcinoma
 - 5. Adamantinoma
- b. Sarcoma
 - 1. Round cells
 - 2. Spindle cells
 - 3. Melanoma

groups. These lesions usually begin as superficial vesicles or bullae, which after a few hours rupture and leave superficial ulcers. They may become secondarily infected with Vincent's organisms, so that too often such patients are needlessly treated for Vincent's infection, when simple questioning would have elicited the etiologic factor. When the causative agent is not recognized, the patient will have a recurrent attack each time the particular drug to which he is susceptible is taken. The lesions, however, will recede rapidly with the discontinuance of the offending drug and the use of alkaline mouth washes.

III. ORAL LESIONS AMONG WORKERS IN
CHEMICALS

Workers in various trades are subject to mucous membrane eruptions. The chemicals to which they are exposed may enter the body through three distinct routes:

First—through the respiratory tract due to the inhalation of the dust of the chemicals.

Second—through the gastro-intestinal tract by the ingestion of contaminated foods and liquids.

Third—small amounts may be absorbed by the skin.

The chemicals most frequently causing oral lesions are lead, copper, mercury, chlorine and phosphorus.

IV. ORAL LESIONS IN SPECIFIC DISEASES WITH CHRONIC INFECTIOUS GRANULOMA

Syphilis affecting the oral cavity may be primary, secondary, tertiary or congenital in character. The primary and secondary manifestations are highly contagious and a source of great danger to their environment. Frequently these patients consult their dentists because of these lesions, and if the dentist does not recognize their nature the chances of infecting himself are very great.

Primary lesions in the mouth are usually masked by the super-added secondary infection, and by the mechanical irritation due to foods. But the acute onset, the absence of local pain, the induration of the lesion, and the characteristic satellite involvement of the regional lymph glands should lead one to suspect a *chancre*.

The chancre of the oral mucosa may take on various forms—a small erosion, a silvery spot, a dry papule or patch, an umbilicated papule or nodule, a purple necrotic nodule, or a crusted ecthyma-like lesion. A single lesion is the rule, but multiple lesions may occur.

The majority of buccal chancres are due to kissing, although intermediate objects also play an important rôle in the spreading of these lesions.

When the primary sore has existed from four to eight weeks, one should expect the appearance of secondary lesions on the skin and mucous patches in the mouth. On microscopic examination, these lesions teem with spirochetes. They are, therefore, a source of great danger and it is from these lesions, which are overlooked, that the dentist may infect himself and others. These lesions are rounded or oval in shape and may be flat, slightly elevated or depressed. They are greyish-white or pinkish in color and are usually covered with a thin loosely adherent membrane. When this is removed, a reddened and often bleeding surface

is exposed. These patches are only slightly painful, but may become sensitive to hot or spicy foods. These mucous patches must be differentiated from the common aphthous stomatitis and herpes. The presence of other symptoms of syphilis and a positive blood test verify the diagnosis.

The tertiary manifestations of syphilis usually met in the mouth are leukoplakia, glossitis, and gummata.

Hutchinsonian teeth are considered pathognomonic of congenital syphilis by most authorities. We do not agree, however, with those who consider the tubercle or carabelli the fifth cusp on the first permanent molar, as a stigma of congenital syphilis.

Tuberculosis of the oral mucosa may occur in one of the three clinical varieties:

First—*lupus vulgaris*, which is usually an extension of the disease from the nose or face with the hard palate as the site of predilection.

Second—*tuberculosis ulcerosa*, which is an ulcerating type of tuberculosis occurring on the tongue and inner surfaces of the cheeks and lips. The ulcer has a ragged edge, dirty sloughy base and on close inspection is studded with tubercles. It is almost always secondary to pulmonary tuberculosis.

Third—*tuberculosis collaquitiva*, which appears as a gummatous mass and is difficult to distinguish clinically from a true syphilitic gumma. In all three of these varieties of tuberculosis the presence of the tubercle bacilli can be quite easily demonstrated by means of microscopic examination and positive animal inoculation. The treatment of choice in most of these cases is mechanical destruction of the lesions.

V. ORAL LESIONS DUE TO YEAST INFECTIONS

The most common of the yeast infections involving the oral mucosa is "thrush" or "white mouth", which is caused by the air-borne yeast plant "*monilia albicans*" and occurs in nursing infants during the first few weeks of life. It is a superficial mycotic stomatitis appearing as various sized patches or irregular branching streaks of snow whiteness, which closely resemble curdled milk deposited on the mucous

membrane. This velvety growth is not firmly attached to the underlying tissue and it may be easily wiped away. The small patches coalesce to form larger plaques and may even spread to involve the entire mouth. This condition responds quite well to local applications of one per cent gentian violet or a two per cent ferric chloride solution.

VI. ORAL LESIONS DUE TO EXTENSION FROM SKIN LESIONS

There are quite a number of diseases involving the skin of the face and lips which may involve the oral mucosa by direct extension. The more common of these are psoriasis, perleche, eczema, chielitis exfoliativa, and Fordyce disease. The last mentioned disease is characterized by pin-head sized, chamois colored lesions which appear discreetly or aggregated in patches on the vermillion borders and the inner surfaces of the lips and on the buccal mucosa along the line of the teeth. These are caused by the presence of sebaceous glands in the mucous membrane. Aside from the cosmetic defect the condition has no significance.

VII. ORAL LESIONS WHICH ARE OFTEN ASSOCIATED WITH GENITAL LESIONS

Such dermatoses as pellagra, lichen planus, herpes simplex, primary and secondary syphilis, may occur simultaneously on the oral mucosa and genitalia. (In the mouth, lichen planus consists of small, flat, shiny, umbilicated papules, irregular or angular in outline, crimson or violaceous in color, which sometimes coalesce to form large pearly white reticulated plaques or linear streaks. The cheeks and the tongue are sites of predilection. The oral lesions of lichen planus usually do not erode, ulcerate or degenerate. The diagnosis of lichen planus is usually made by the appearance of genital or skin lesions and in this way it is differentiated from leukoplakia.)

Vincent's infection is common and exists in varying degrees of severity and forms of manifestation. The diagnosis is made by finding the characteristic spirilla and fusiform bacilli in smears taken from the lesions.

VIII. LESIONS INCIDENT TO PREGNANCY

Menstrual herpes or "recurrent cold sores" are occasionally noted in women at the menstrual period. Some patients show extensive erosions of the lips recurring with each period.

Aphthous stomatitis is not infrequently observed during the menstrual period. The apthae usually appear about three days before each period, rapidly disappearing at the end of the period only to reappear three days before the next period.

Increased salivation to a point where the symptom is a distressing one is not unfrequently observed during the menstrual period.

Menstrual Toothache. Menstruation is occasionally ushered in by a toothache of the neurologic type, which appears suddenly several days before the menstrual period. The toothache has been shown to be due to a congestive hyperemia in the periodontal membrane about a pulpless tooth from the circulatory changes involved in menstruation.

If the patient happens to be suffering from any other oral lesion, there may be an exacerbation of these lesions during the menstrual period.

IX. ORAL LESIONS INCIDENT TO PREGNANCY

Gingivitis gravidarum is a special form of gingivitis which begins about the fourth month of pregnancy and persists until after parturition or well into the period of lactation. It is characterized by swelling and tissue hyperemia of the marginal gum tissues. Tenderness of the gums is frequently marked and profuse bleeding often occurs on brushing the teeth. In marked cases extreme hypertrophy of the gingivae may occur, giving rise to polypoid growths, which often cover the crown or cutting edge of a tooth. These hypertrophic tumors usually recede spontaneously after labor.

Benign new growths, caries, neurologic dental pains and transitory benign plaques of the tongue are often noted in pregnancy and disappear after parturition. It is important to recognize such conditions so that needless surgical intervention does not take place.

X. DISEASES OF THE TONGUE

Practically any condition which may affect the oral mucosa may be localized to the tongue, so that many books have been written on diseases of the tongue. There are, however, several conditions which are limited to the tongue and are worthy of discussion.

Lingua geographica, or "Butlin's Wandering Rash", is a benign condition occasionally seen on tongues of individuals who are not conscious of its existence, since its presence does not cause any symptoms of discomfort. It is characterized by irregular patches of superficial erosions more or less sharply circumscribed. The picture changes from day to day and may involve the entire dorsal surface of the tongue or only the edge. Very often it will disappear entirely for a while only to reappear in a different area.

Moellers glossitis usually occurs in women past 45 years of age. It is characterized by atrophy of the papillae, giving the tongue a smooth glossy appearance in some areas, together with superficial erosions or ulcerations in others. Pain and burning are often pronounced symptoms, making it difficult for the patient to eat or drink. The cause of this condition is unknown and the treatment has not been very successful. Constitutional therapy, together with the use of milk alkaline mouth washes may alleviate some of the pain. The disease may last for years with periods of remission. Occasionally it will disappear spontaneously.

XI. ORAL LESIONS DUE TO CONGENITAL ABNORMALITIES

The most frequent of the congenital abnormalities is probably the *scrotal* or *furrowed tongue*. The organ is generally larger than normal and there are plicate, superficial or deep grooves, usually arranged so that there is a longitudinal furrow along the median raphe, with shorter grooves on each side. The condition gives rise to no difficulty and treatment is not necessary, except that deep furrows should be kept clean with mouth washes.

Black hairy tongue or *hyperkeratosis linguae* occurs on the dorsum of the tongue, anterior

to the circumvallate papillae, where there are formed black, bluish-black or brown patches consisting of hair-like intertwining filaments from $\frac{1}{4}$ to $\frac{1}{2}$ inch in length. The condition is not due to microorganisms as in cases of pseudo-black tongue, but is due to some congenital abnormality which may develop in later life.

XII. CYSTS OF THE ORAL CAVITY

Cysts occurring in the oral cavity may be divided into those of the soft parts and those of the bony parts. The former group includes the simple mucous retention cysts, retention cysts of the tongue, ranulae, thyroglossal cysts and dermoids. The latter group includes cysts of the dental and alveolar regions, such as periosteal root cysts, and follicular cysts, and naturally falls strictly in the realm of dentistry.

Simple retention cysts are cystic dilatations of mucous glands or their ducts due to retention of normal secretions. They may occur anywhere in the mucous membrane of the mouth where glandular structure is found. Since the lips are abundant in mucous glands and are prone to injury, cysts of this type are usually found here. They form protuberances varying in size from a pea to a hazel nut and have a slate or slightly bluish color due to the serous or mucous contents shining through a thinned mucous membrane. On incision a glairy ropy mucous escapes. If the opening is allowed to close, the tumor shortly reappears.

Retention Cysts of the tongue are small, marble-sized cystic dilations of the anterior lingual glands, following the occlusion of their ducts they are observed on the under surface of the tip of the tongue to either side of the median line.

Ranula is a term usually applied to include all cystic swellings of the floor of the mouth regardless of their form or origin. The term should be confined, however, to cystic dilatation of the duct of the sublingual or submaxillary gland. Persistent obstruction to the flow of saliva due to stones, or any occlusion of the outlet leads to the development of a cyst-like dilatation of these ducts. They are laterally situated tumors, oval, finger-shaped or globular; transparent, tensely filled with a ropy,

mucous fluid resembling a white of an egg. They may vary in size from a small marble to tumors filling the oral cavity and causing swelling in the face and neck. Ranulae must be differentiated from the less commonly occurring dermoid and thyroglossal duct cysts.

XIII. BENIGN TUMORS OF THE ORAL MUCOSA

Almost every benign tumor found in the human body may occur in the oral cavity. Among these may be included tumors of the vascular system, fibromas, lipomas, and keloids. (In addition, tumors derived from the dental system as adamantinomas, epuli, odontomas and the various dentigerous cysts are encountered solely in this cavity.)

The *papilloma* is probably the most frequently observed tumor in the oral cavity. It occurs anywhere on the oral mucosa and varies from a pea-sized to an extensive verrucous growth, bleeds easily and is subject to ulceration. The favorite sites of such growths are the tongue, gums, uvula and the pillars of the fauces. They are usually due to chronic irritation. Verrucae or warts may occur on the oral mucous membrane associated with similar lesions on other parts of the body. The theory that warts are caused by a filterable virus, and that oral lesions result from autoinoculation seem to have been conclusively proven.

Angiomas are tumors in which the blood or lymph vessels constitute the most prominent part. Where the blood vessels predominate, such tumors are called "hemangiomas"; where lymph vessels constitute the chief portion of the growth, the tumors are designated "lymphangiomas". These tumors may vary in size and structure from the simple purplish-red varicies, commonly called the "blood blister", to large cavernous hemangiomas which may involve the greatest portion of the tongue and lips.

Adenomas are tumors arising from the mucous glands of the mouth. They occur in two distinct forms, the one giving rise to small pin-head to pea-sized tumors of the palate, the second causing large, clumsy swelling of the lips, macrochilia, the so-called "double-lips".

Benign giant cell tumor or *Epulis* has in the past been used to imply any periosteal tumor on the alveolar process, regardless of its histological structure. Today, usage has limited the term to designate two types of tumors, the fibrous type, or *epulis fibromatosa*, and the giant cell type, or *epulis sarcomatosa*. These tumors are benign, yet show a marked tendency to local recurrence. They are of slow growth, except in pregnancy, when rapid increase in size may ensue. As a rule, these tumors are located on the labial and buccal side of the alveolar process, only rarely being observed on the lingual side.

Adamantinomas are true tumor formations, apparently arising from the peridental epithelium. They are solid or cystic new growths arising within the alveolar border. By slow growth they gradually distend the ramus of the jaw, often reaching enormous size to project into the oral cavity. The solid type is more commonly found in the upper jaw and the cystic type is usually found in the lower jaw. The adamantinomas are of a low degree of malignancy, but are slowly progressive and have a marked tendency to recurrence after removal.

XIV. PRECANCEROUS ORAL LESIONS

While the specific cause of cancer is yet unknown, it is now pretty well agreed that repeated irritation, definite disease entities and other inflammatory processes in the tissues play a rôle in the causation of cancerous growths. Many patients presenting themselves with certain malignant new growths in the mouth give a history of some previous injury or condition, such as leucoplakia, syphilis, tuberculosis, cysts, burns, etc.

The importance of removing all irritative factors such as excessive smoking, ill-fitting dentures, and poor oral hygiene, and the judicious treatment of those mouth lesions which may develop into definite malignant lesions cannot be overemphasized.

THE ROENTGEN-RAY AS AN AID IN OBSTETRICS

By LOUIS J. GELBER, M.D., Newark, N. J.

Delivered before Section of Obstetrics, Surgery and Gynecology of the Newark Academy of Medicine
on March 1, 1934.

When we consider that over 18,000 women die each year during childbirth in this country alone, it would appear that any adjunct lessening this mortality would promptly receive a general acclaim by the medical profession. By a routine roentgen examination, the roentgenologist can now obtain more information regarding the size, form, and position of the fetus in utero and the relationship that the head bears to the pelvic canal than the obstetrician might possibly tell by his most painstaking examination extending over months of observation. It appears that the time is rapidly approaching when the "roentgen examination" will be a routine procedure in practically every case of pregnancy.

The following are some of the obstetrical problems for which roentgenology can be relied upon as an aid to a certain degree: position and presentation of the fetus; diagnosis of intra-uterine death; differentiation of pelvic tumors from pregnancy; and discovery of disproportion between the outlet of the pelvis and the foetal head.

The roentgen diagnosis of intra-uterine pregnancy is a comparatively new field of study, but, according to Falls, some cases date back to reports in 1899. Roentgenology as applied to obstetrics is used routinely in many clinics where pathological presentations, abnormality of the fetus, or multiple pregnancies are suspected.

The roentgen diagnosis of foetal death has long been a matter of much discussion. The roentgen signs, however, which are most frequently observed are over-lapping of the skull bones, collapse of the thorax, and angulation of the spine. Where the roentgen estimate of age is significantly less than the duration of gestation, the probability of a dead fetus must be taken under advisement.

Negative roentgen findings in the third and fourth month of pregnancy are not uncommon. In the fifth month, however, one receives positive findings. An extra-medial posi-

tion of the fetus is indicative of extra-uterine pregnancy only when the skeletal parts of the child coincide with an isolated tumor near the uterus. In an extra-uterine pregnancy that has gone to term, the fetus is placed quite asymmetrically in the pelvis.

In order to recognize the earliest sign of osseous development, it is an important fact that the bladder be emptied before photographs are taken. The intestines should also be emptied thoroughly by enema because faecoliths or fillings with contrast substance produced by gases in the intestines often render impossible a recognition of the fetal parts. The skull and the adjoining vertebral column apparently are the earliest recognizable parts. In fact, the roentgenogram of the fetal skeleton is the earliest demonstrable positive sign of pregnancy. In spite of the fact that it has been stated by many that the fetal skeleton can be detected on an x-ray film as early as three and one-half or four months, this is very difficult to say. Even when a good film has been obtained as early as the fourth month, the entire skeletal structure cannot be outlined in so far as only a portion of the skull or a few vertebrae may appear. However, it is important to know that the occipital bone is usually the first bone to be observed. As far as the vertebral column is concerned, it seems that the cervical vertebrae are the first to make their appearance, and others appear progressively down throughout the entire spinal column.

We must also not lose sight of the fact that ossification centers occur in the occipital bone as early as the eighth week, as well as the ossification centers in the upper cervical vertebrae; yet in spite of this the x-rays will not cast shadows until enough calcium is deposited in these bones. The result is that roentgenograms taken at about four and a half months will reveal the earliest signs of pregnancy. When the fetus happens to lie transversely in the uterine cavity with its back presenting, almost the entire foetal skeleton will be observed on this plate.

Gas, and intestinal and pelvic contents, together with the tilt of the pelvis and relation of the sacrum to the skeletal shadow, may offer sufficient resistance of the passage of the rays through the pelvis, so that the resulting accumulation of shadows apparently wipes out the early foetal skeletal shadows on the films. These conflicting shadows illustrate to us how important the adequate preparation of the patient is.

Another important point in taking x-rays of the fetus in early pregnancy is the position of the patient. The uterus before mid-term does not rise high into the abdomen. Therefore, if the roentgenogram is made in a straight anterior-posterior or posterior-anterior position, the fundus which lies below the level of the iliac crests is covered by the shadow of the sacrum with its dense promontory, and the fifth lumbar vertebrae. With the patient lying prone on her back in a position of increased lordosis produced by placing sand-bags underneath the lumbar spine, and the central ray directed through the pelvis in the axis of the superior strait, the entire true pelvis can be seen from below upwards without any overlapping of the sacral or pubic shadows. Besides fetal structures might be shown if the patient has been well prepared. We must, however, bear in mind that the liquor amnii, increased amount of blood to the uterus, scattered radiations from the enlarged maternal structures, poor lime deposit in the fetal bones, intestinal contents, and over-lying pelvis structures all tend to increase the difficulty of projecting good fetal shadows.

In view of our present-day knowledge, the roentgenologist and the obstetrician who understand their problems may proceed without fear of doing harm to the fetus regardless of its stage of development, because it has been estimated that in making a film of the pregnant uterus only about one-fiftieth of an erythema dose is used. Furthermore, the affects of x-ray radiation on tissues in general are usually exhausted in about four weeks; and hence one may feel safe in exposing the fetus in utero several times during a given pregnancy, provided it is done about every month. Warnkros, of Dresden, has taken numerous con-

secutive roentgenograms consisting of eighteen exposures during the mechanism of labor and even during actual delivery, and has noted no ill-effects upon the child. Therefore, we may conclude that four or even five roentgenograms taken during a given pregnancy will certainly not harm the fetus.

X-rays are indeed a great help to the obstetrician when sometime his back is against the wall, as in the following example: A young healthy woman pregnant for the first time and of full-term had been in labor about fourteen hours without progress. After careful examination, a cesarean section was decided upon. This was done and an anencephalic monster was delivered which died in a few minutes. You can imagine the great amount of criticism that this obstetrician had received from the family. However, if a roentgenogram had been made before operation, the family could have been informed of the true state of affairs and an operation saved. Luckily the mother recovered, but the obstetrician did not.

Many a surgeon and gynecologist has had the experience of entering the pelvis to remove a fibroid uterus and find to his surprise that a four or five months' pregnancy was present. Not only would a suit for malpractice be saved but also much embarrassment, if the physician follows the simple routine of taking a roentgenogram where doubt exists.

In so far as the incidence of cesarean section is obviously on the increase, and while the mortality is considerably less than it was ten years ago, there is still room for improvement. There is no doubt that there is no operation more satisfactory for the working of good obstetrical practice than performing a cesarean section where indicated if the baby is alive and normal. It is extremely important to save a woman from undergoing an unnecessary major operation which may endanger her life by eventually extricating a malformed or dead fetus. Because of this point alone, it certainly does speak for routine roentgen-ray exposures before every cesarean operation where practicable.

Finally, a roentgenogram not only gives us information about the bony structure of the pelvis, but also tells us the position of the fetus, the number of pregnancies present,

whether the fetus is a monster or whether it is dead; and also tells us whether we are dealing with pelvic tumors simulating pregnancy or any of the concurrent miscellaneous conditions.

I might conclude by describing a case which recently occurred in Tennessee, and which will vividly bring forth the medico-legal advantage of x-rays used by physicians and surgeons doing obstetrical surgery.

The patient, aged 26, first consulted the physician, telling him that her belief was that she was pregnant in so far as her last menstrual period had

occurred four months previously. She was then examined. She was told that she had an ovarian tumor and an operation was advised. Upon operation, she was found to be about three and one-half months pregnant. The defendant physicians thereupon closed the incision. Bleeding grew worse while the patient was in the hospital, and miscarriage occurred about two weeks after the operation. A suit was brought against the physician on the ground that the operation was performed because of a mistaken diagnosis, and the verdict was in favor of the plaintiff.

References: S. Zeilo F., *Archive Gynak*—1931, 145, 495, 511; Dr. De Lee, *Principles & Practise of Obst.*, 1928—P. 282-283; Kerr and Rypins, *Roentgen Diagnosis of Fetus Papyraceus in Utero*, *Amer. Jour. of Roentgenology*, pp. 89-91; Mathews, *Amer. Jour. of Obstetrics & Gyn.*, *Haskins vs. Howard* (Tennessee) (16 S.W.) (Sec. 20).

AMEBIC DYSENTERY AND THE GENERAL PRACTITIONER IN NEW JERSEY

By MANFRED KRAEMER, A.B., M.D., and MAURICE ASHER, M.D., Newark, N. J.

The principles which were in part shown in graphic form in a scientific exhibit by the authors at the Annual Meeting of The Medical Society of New Jersey at Atlantic City, June 5-7, 1934, and at the Annual Meeting of the American Medical Association in Cleveland, June 11-15, 1934

The purpose of this communication is to call to the attention of physicians the prevalence of amebiasis in New Jersey; the clinical picture of the disease; a practical method for making the diagnosis; measures to be taken to treat infestation; and the epidemiology and the prevention of dissemination.

PREVALENCE

The Chicago epidemic of 1933 focused attention upon amebiasis. Most practitioners had hitherto considered it of a tropical nature and a medical curiosity in this region. However, we reported five cases occurring in our private practice in the year prior to the Chicago Fair, ending June 1933. To make more vivid the incidence of amebiasis in private practice—in the year ending June, 1933, we saw more cases of amebiasis than of such oft discussed and written about acute conditions such as perforated peptic ulcer, diverticulitis of the colon, and empyema of the gall-bladder. Prior to the Chicago epidemic there were cases of amebiasis coming from New Jersey reported at the Mayo Clinic. In 1930 a student nurse at the Newark Presbyterian Hospital died of amebic dysentery contracted in New Jersey.

The practitioners and health authorities of

New Jersey must realize that amebiasis is endemic in this state. We must be on the alert for this disease, not only in travelers from the Century of Progress Fair and the tropics, but in every patient presenting himself with a looseness of bowels.

SYMPTOMS

The symptoms of amebic dysentery are tenesmus, looseness of bowels and weakness. In our experience tenesmus is the most marked feature in the acute cases. The patient often says, "I must go to the toilet ten or twelve times a day and strain, and all I pass is a little mucus." This is in contrast to the frequent profuse discharges of blood and mucus in ulcerative colitis. There is usually not much pain, although there may be occasional colic. Various vague gastro-intestinal complaints may be noted.

DIAGNOSIS

We have made it a routine practice to use the proctoscope in examining the rectum of all cases of diarrhea. In amebiasis the rectal mucous membrane often presents typical small punched-out ulcers surrounded by normal mucous membrane. With a wooden applicator

we remove a scraping from the surface of such an ulcer; or, if no ulcers are seen, from the rectal or sigmoidal wall. No cotton is used on the applicator. The scraping is transferred to a drop of warm physiological saline solution on a warm slide, and is examined at once with the microscope.

In cool weather it is necessary to keep the stage of the microscope warm as the amebae cease to move on cooling. No elaborate warm stage is required. The usual microscope stage may be kept warm by focusing upon it the rays of a large electric light bulb. We have used a sheet of copper with a perforation for light. This copper is warmed to body temperature, placed upon the stage, and the slide laid upon it. The copper plate retains the heat long enough to keep the amebae warm during the examination.

One must search for *motile* amebae containing ingested red blood cells. A diagnosis can not be made on dead or non-moving amebae as it is impossible in unstained fresh specimens to differentiate between dead amebae and macrophages containing red blood cells; and between dead amebae and large epithelial cells.

If the patient cannot come to the office, the microscope must be taken to the bedside. Where a proctoscope is not available, the patient should be given an ounce of magnesium sulphate by mouth. This will produce a liquid stool which should be examined as soon as passed. In a hospital the technician must come to the bedside when the patient has a desire to move the bowels, and must collect the specimen in a warm pan and examine it microscopically at the bedside. In the office the specimen must not be put aside until time is available, but must be examined when passed.

An impression exists that in order to diagnose amebiasis a stool specimen should be sent to a pathological laboratory where a diagnosis will be made. This impression is erroneous. By the time a liquid stool reaches a laboratory, no amebae remain alive. They are frequently digested by the bacteria in the stool if kept warm; or they may be killed by cold if chilled. In any case with loose bowels the physician or laboratory man should be called to examine the specimen when removed from or passed

by the patient. No liquid stool should ever be sent to a laboratory for an examination for amebiasis. The living amebae is ten times the size of a red blood cell. It is found with the low power lens of the microscope, and is then studied with the high power lens. We feel that any practitioner able to examine urine and blood smears microscopically should attempt to find amebae either from rectal scrapings or immediately from a freshly passed stool as described. Only if the physician's findings are uncertain or negative should it be necessary to call a consultant.

In chronic cases and in carriers the entamebae undergo encystment. The cysts are found in the formed stools passed by patients of this class, and will survive many weeks in moist formed stools. They are destroyed only by excessive heat and drying. A formed stool from a chronic case or carrier may be sent to a laboratory for an examination for cysts. A working rule is as follows:

In dysenteric stools *living amebae* are found.

In formed stools *cysts* are found.

The average laboratory technician is not capable of finding cysts if they are present. Unless a laboratory worker has special training in protozoology he will confuse many cells normally seen in the stool with amebic cysts. Most workers in public or private laboratories are unfamiliar with the cysts of the various amebae and should not be trusted to examine these specimens. The living ameba is large and easily found; the cyst is almost as small as a red blood cell. For diagnosis in chronic cases the stools should be sent by the physician only to a worker trained in protozoology. The examiner must search at least an hour before he should declare the stool negative. Three negative stools examined at intervals of several weeks are required to determine freedom from cysts.

TREATMENT

Unless the dysentery is severe, the patient need not be put to bed. We have our patients call at the office for ten daily intra-muscular injections of one grain each of *emetine hydrochloride* which is marketed in solution in one c.c. ampoules. No more than a total of ten

grains should be given to an adult, since it is quite toxic and very slowly eliminated.

We supplement emetine with a course of *Vioform*, grains four in capsules t.i.d. for ten days, repeated at intervals of one week, one month, and three months, even though the patient is free from symptoms. The claim is made for *vioform* that it is a specific against amebiasis. The drug is described on page 228 of the 1934 edition of "New and Non-official Remedies", published by the American Medical Association.

Many workers have found *carbarsone* (Lilly) very effectual.

The patient should be placed upon a roughage-free, high-protein, high-vitamin, low-carbohydrate diet. He should be warned to scrub his hands thoroughly after leaving the toilet.

In cases which do not respond to emetine and in whom diarrhea is severe, large doses of *bismuth* are recommended, and *opium* should not be spared. It has been suggested that in intractable cases rectal irrigations of hot water (118° F.) be used; or that caecostomy be performed and the colon irrigated through the caecostomy wound.

PREVENTION

Any discussion of the prevention of amebiasis must be based on a clear understanding of its epidemiology. There are three common methods by which amebiasis is disseminated in the North Temperate Zone.

1. By the contamination of drinking water by sewage either at reservoirs, or because of faulty plumbing in hotels and public buildings. Defects in plumbing caused the recent Chicago outbreak.

2. By cyst-contaminated vegetables shipped from the South.

3. By cyst-infested handlers of food, whether they be hotel employees or housewives.

THE APPROACH TO PREVENTION

First, public health authorities should check the plumbing in all hotels and public buildings. Any connecting valves between the water supply and the sewage systems should be elim-

inated, as also should out-moded toilet bowls from which, if clogged, sewage might be siphoned into the water pipes.

Second, housewives and cooks should thoroughly wash all fruits and vegetables shipped from the tropics and eaten raw. The sporadic cases caused by the ingestion of cyst-contaminated fruits and vegetables shipped from the South will be most difficult to prevent. Until the dysenteric farm hand uses the flush toilet instead of the open field, and until farms universally use irrigating water from uncontaminated sources, uncooked vegetables will ever be a possible source of amebiasis.

Third, the detection and elimination of amebae carriers would seem to be of major importance; but to isolate from the restaurant trade the large number of cyst carriers scattered throughout the country, would be impossible for they have been estimated by competent investigators to exceed five million. The routine examination of stools of food handlers as now practiced is a mere gesture. The search for cysts in stools is an exasperating process, requiring many examinations. A skilled microscopist can examine ten stools per day. Three stools passed at intervals of several months must be examined before a food handler can be declared free from cysts.

WASHING THE HANDS

If a food handler or cook thoroughly washes his hands and dries them on a fresh clean towel immediately after using the toilet, he will not contaminate any food. If in New Jersey many restaurant lavatories are as poorly supervised and as filthy as some which we have seen, it is little wonder that amebiasis is endemic here.

Physicians should take up a crusade for ordinary cleanliness. Health officers must enforce ordinances providing that food handlers thoroughly wash their hands with soap and hot water and dry them on freshly laundered towels after each visit to the toilet. Persons known to harbor cysts render themselves innocuous if they use this ordinary hygienic care. The procedure will also prevent the transmission of the germs of typhoid fever and other intestinal diseases.

UROGENITAL TUBERCULOSIS

By STANLEY L. WANG, M.D., New York City

From the Department of Urology (James Buchanan Brady Foundation), New York Hospital, New York City.
Read before the Bergen County Medical Society, Hackensack, N. J., March 13, 1934.

There is an increasing interest in urogenital tuberculosis. Methods of its diagnosis have gradually improved and become more accurate, and the possibility of its occurrence is being given more consideration. It has followed that a larger number of patients are appearing for treatment.

FREQUENCY

How frequently the genito-urinary tract is the seat of tuberculosis is not very clear. It is confused because the various organs are often involved in a generalized tuberculosis spreading from the lungs. Thus Hobbs in reporting 1000 autopsies on patients dying from pulmonary tuberculosis stated that in 16.2 per cent there were clinical evidences of renal tuberculosis. Microscopic tuberculosis was found in 32 per cent of a small series of kidneys from these cases. In our work we are more concerned with the class of patients in which the active tuberculosis is localized in the urogenital tract, although there may be inactive foci elsewhere. Caulk reported that 30 per cent of all surgical lesions of the kidney were tuberculous. Others have placed the incidence as high at 40 per cent.

The route by which tuberculosis is brought to the urogenital tract is generally believed to be the blood stream. Previously there was considerable belief that the infection was of ascending character, but such instances were probably infrequent. The lymphatics may play some part in the extension of the disease between the organs within the tract.

The primary infection is thought to occur usually in the epididymes, seminal vesicles or kidneys.

TYPES

As for the types of lesions and their distribution there is a wide range and there is not time to attempt much of a description. Clinically, tuberculosis of the kidneys and of the

epididymes are most often encountered. In the kidneys one is more often involved, but bilateral disease is seen in a more or less certain percentage. Then it is more extensive in one kidney and to a lesser degree in the other. Much loss of function due to destruction of renal tissue is usually followed by compensatory enlargement of the other kidney. In the chronic types of renal lesions cavitation is often seen with partial or complete destruction of the organ. The perinephric fat is sometimes noted to have undergone changes which may or may not have to do with subsequent post-operative sinus formation. Infection of the ureters and bladder are thought to be secondary to renal disease. In the epididymes, which are rather frequent sites for tuberculosis, it is thought the bacilli lodge beneath the epithelium of the tubules and produce tubercles which caseate, fill the organ with pussy caseous material, and cause an enlargement of the whole structure. The testicle and vas deferens are affected by extension from the epididymis.

It has been suggested that chronic pyelitis, cystitis, urethritis, epididymitis and trauma might predispose to urogenital tuberculosis. However, it is doubtful if there are any special predisposing causes.

SYMPTOMS

The symptoms cover a wide scope, and in varying degrees of intensity. The distinguishing characteristic of the symptomatology is its *insidiousness* of onset. But this is not a fixed rule for there are numerous exceptions. Patients may relate how their trouble began with severe initial symptoms. Some will connect the onset of the symptoms with an injury, errors in diet, or over indulgence in alcohol or sexual affairs. An extensive area of disease may be discovered in such patients, which suggests that the event may have been the means of uncovering a "silent" lesion that had existed for a long time.

The general or constitutional symptoms are

much the same regardless of which organ is involved. There is often little or no apparent constitutional evidence; and one has the paradoxical position of suspecting tuberculosis in a patient whose general appearance is that of health. Usually the more widespread the lesion and the longer its duration, the greater the likelihood of general symptoms. Perhaps one of the first noticeable signs is a loss of strength and tendency to tire easily; or a feeling of lassitude and a lack of initiative. A gradual loss of weight often occurs. Quite a few mention chills and sweats, and a slight daily fever. Gastro intestinal disturbances, nervous instability, and insomnia are not uncommon.

RENAL TUBERCULOSIS

The local symptoms of renal tuberculosis vary widely in their number and in their severity. There are patients who insist they are free from symptoms and their ailment is discovered casually. For example, a young girl was seen recently whose urine was found to contain a few pus cells when she was examined at an annual physical examination. Further search revealed tubercle bacilli in the urine, and an advanced unilateral renal tuberculosis. The symptoms depend to some extent on whether the lesion is a rapidly developing miliary type or of a more chronic phthisical nature. In the miliary types, symptoms referable to the kidney are not as clearly defined. In those of a chronic character, which are more often seen, the first are usually disturbances in urination. However, it is rather surprising how many describe their first symptom as an aching pain in the lumbar region or in the flank on the side of the affected kidney. Frequency of urination with or without burning is the commonest complaint. Urgency and pain in the bladder are sometimes associated with the frequency. Hematuria is important and in a number is the first evidence. The amount of blood varies from small quantities to large recurring amounts. The urine is usually acid and clear except when clouded by pus or blood cells. Tubercle bacilli can be found in the urine of most patients. Guinea pig inoculation is considered more certain but examination of the urine sediment yields ac-

curate results. The sediment examinations do not have the disadvantage of the delay incident to guinea pig inoculations. It is our practice to make thin slides of the sediment and then place the slides in the incubator for twenty-four hours. This fixes the smears satisfactorily and they can be readily stained by the usual technic. Examination of separate specimens from each ureter is desirable. Local swelling of the kidney can occasionally be felt or there may be a feeling of pain on palpation. In more than a hundred patients ill with inoperable or postoperative renal tuberculosis not a few of whom had more or less tuberculosis nephritis, I have never seen high blood pressure.

The symptoms often indicate the nature of the illness, but a comprehensive idea of the lesion and how it should be treated cannot be gained until pyelograms, cystoscopic examination and renal function tests, preferably from each kidney, are made. Pyelograms retrograde or intravenous show the characteristic feathery shadows, indicate the extent of the infection and are frequently suggestive in a general manner of the function. The phenolsulphonphthalein dye tests and the urea excretion from each kidney are valuable in appraising the renal function. Blood chemistry, especially urea nitrogen estimations are helpful.

Ureteral tuberculosis does not present many symptoms. Pain may be noted along the course of the ureter and enlargement might be felt in thin patients. The diagnosis is made from the pyelograms.

BLADDER INVOLVEMENT

The symptoms of tuberculous bladder are those of cystitis. Urinary frequency, burning, pain and urgency together or in different combinations. The condition of the interior of the bladder can be determined by cystoscopy. The lesions are most often seen around either or both ureteral openings or in the trigon. At the outset there is a reddened injected area. Later the redness becomes of a deeper hue and the normal glossy appearance changes to dullness. Ulceration subsequently ensues with the development of shallow irregular ulcers. It has been our experience that dull red thick-

ened lesions are seen more often than the typical tuberculous ulcer. Widespread ulceration with trabeculation lessens the bladder capacity which is of importance in prognosis.

EPIDIDYMIS SYMPTOMS

In the epididymes the diagnosis is not always easy. One side is mostly affected, but in a number it appears at a later time on the other. Renal and epididymal tuberculosis are not infrequently seen together. Gradual development of the signs and symptoms is customary; but in some the onset is sudden and painful with acute swelling which simulates other infections. Injury may aggravate a previously unknown lesion and it may be necessary to wait before the etiology can be recognized. Recognition of the cause is of added importance in injuries of patients insured under the workmen's compensation laws. In the usual early case the symptoms are slight. A small nodule in the epididymis may be the only change. Later the swelling increases, accompanied by some local tenderness and degree of pain, often described as a draggy sensation. The globus minor is most often involved and then as the disease spreads through the epididymis it can be felt as a heavy, doughy irregular mass separated from the testicle by a distinct sulcus. Thickening and nodules in the vas deferens confirm the diagnosis. If the disease is not extirpated surgically, it will spread to the testicle, which enlarges with disseminated foci that are felt as soft spots. Finally the scrotum is swollen with a mass in which the organs can be differentiated with difficulty and external sinuses form discharging caseous pus.

PROSTATIC SYMPTOMS

In the seminal vesicles and prostate there is little disturbance at the outset. Slight symptoms from the bladder neck, pain in the rectum and at times sexual disorder. The vesicles are felt to be thickened. The prostate is somewhat enlarged, nodular and soft areas may be felt. Tubercle bacilli should be searched for in the prostate secretion.

TREATMENT

The treatment of choice for urogenital tuberculosis is a combination of urological treatment with the general and special care of tuberculosis. It is the surgical removal of the active lesion followed by a long course of dietetic, hygienic and other measures and procedures which have been found useful.

Some patients refuse to be operated upon. The unsatisfactory course of most of such patients is convincing proof of the efficacy of surgery. Skillful surgery which implies a knowledge of how much to remove and the best method of doing it changes the picture from a sick to a convalescent patient, limits the spread of the disease as a rule, and prevents further impairment of the function of the genito-urinary tract.

The care and treatment of inoperable and postoperative patients are worth particular attention. At the Urological Department (James Buchanan Brady Foundation) of the New York Hospital a special clinic for this group has worked out satisfactorily. Beginning in a small way it has grown and there are now two physicians, a dietetician and laboratory technician engaged in carrying it on. The treatment is rather difficult to describe for it is based on the plan of building up a regimen to meet the individual needs. It seems to fall logically along two lines—the *urological* and the *tuberculosis*.

The urological care varies with the many different aspects of the disease in the urogenital tract. In general, it includes as indicated bladder instillations and irrigations, cystoscopic observations, renal lavage, prostatic and seminal vesicle treatments, fulguration of bladder ulcers and additional surgical procedures as the need arises.

The tuberculosis care consists of rest, fresh air, proper diet, quartz light irradiations, tuberculin and medicinal therapy. Selection of foods, omitting those that are irritating to the diseased urinary tract, has been the means of relieving a number of patients and it is a very interesting phase of our work. A modified high alkaline ash diet is useful as a starting point, continuing or changing it with the Ph of the urine as a guide. We have found tuber-

culin a worthwhile adjunct. The quartz lamp heals postoperative sinuses and exposures over the regions of the kidneys and bladder are a part of our plan. We are also irradiating the interior of the bladder with the quartz lamp as part of our care of bladder complications. A lamp with a special quartz applicator built to the specifications of Dr. Oswald S. Lowsley and the writer has given encouraging results. Viosterol and cod-liver oil are administered, also methylene blue for the relief of burning on urination.

	Inoperable Patients	Postoperative Patients
Well	3	22
Constitutionally well	12	38
Local symptoms }		
Retrograding	11	22
Died	2	4
	—	—
	28	86

Table Showing Results of Treatment in 114 Cases

In the accompanying table are the results of treatment of 114 of our patients. The inoperable were diagnosed as being unsuitable for surgery, or surgical care had been refused. The results are not as good as in the postoperative group. The disease is often more extensive and their sufferings more intense. Still, considerable relief is often obtained.

Placing them on a carefully thought out regimen frequently brings a marked alleviation of symptoms. It is well to be cautious about advising patients they are inoperable for an operation may later be necessary to prolong life. In our series we have had several instances where removal of the worst kidney in bilateral renal tuberculosis became advisable, and they have gotten along exceptionally well.

In the postoperative group the results are best. They comprise about all the usual types of urogenital tuberculosis patients and the treatment has the best effect. In both inoperable and postoperative the constitutional improvement is often remarkable. Where local symptoms persist much can often be done for the patient's comfort.

In concluding, the results of treatment are better in the earlier cases for surgery and post-surgical care can be best applied. Early diagnosis depends much on the investigation of symptoms and findings that may seem minor in character. Successful treatment is more likely when the urological and tuberculosis treatment are combined. Completeness of the regime is essential, for no single part of the plan has received general endorsement that it alone will arrest the tuberculosis lesions.

I believe more patients become well than are commonly thought.

THE PHILOSOPHY OF MEDICAL SERVICE AND ITS PRESENT-DAY APPLICATIONS

By FREDERIC E. ELLIOT, M.D., Brooklyn, N. Y.,

Chairman, Committee on Medical Economics of the Medical Society of the State of New York
Abstract of an address given before the General Session of the 168th Annual Meeting of the Medical Society of New Jersey on the evening of June 5, 1934, in Atlantic City

Opposing the efforts of the people who are trying to improve the provision of medical care to the public, I should like to demonstrate the fact that we are thinking and working *constructively*, not alone in the neighboring State of New York, but here in Jersey, in Pennsylvania, in Massachusetts,—in fact, all over the country.

It is now beginning to be recognized that the *family doctor* is the real guardian of health, and that if this guardianship were permitted to grow up apart from the practice of medicine, it would not be the true guidance.

I should like to go into the work of Health Commissioner Vaughan's work in Detroit in bringing eleven hundred physicians into active participation in the public health activities of that city, resulting in closing the clinics of the Health Department, in reducing the cost of public health to the taxpayer, and in increasing the efficiency of the work of his department. I should like to tell you the story of the extension of that program into other communities. You in New Jersey have adopted the plan—the Public Health Hour of the practicing physicians—as a major project of your State Medical Society.

Also I should like to take up the work that is being done in a large number of centers on the dole of free medical care, which so seriously threatens the integrity of the medical profession today, which threatens the continuity of our present standards of practice, and the continuous growth of medical knowledge.

We have been quite slow as a group to challenge the issue of unlimited and uncontrolled charity medical care to people who were not economically entitled to that service. In New York, Boston, Philadelphia, St. Louis, and Cleveland (in fact, the movement is widespread), control is beginning to be exercised over the open doors of the clinic.

I should like to discuss the assertion that the provision of medical care is a *business*, as contrasted with the practice of medicine as a *profession*. The layman who obtains medical care knows that we must pay for it, and we are beginning to give him rational assistance in plans for meeting that expense. Considerable work has been done along that line, and there is an effort now being made to promote a campaign of education to induce our people to store away a reserve fund to meet that unpredictable instance of disease and accident about which some of our erstwhile friends are so concerned.

I should like to speak about the necessity to modernize the organization of medicine, and to introduce trained experts to serve our group in order to do for us what only group action can do. You in New Jersey have set an excellent example in employing a full-time Executive Secretary to do just this kind of work.

I should like particularly to go into the fact that our dues to our medical clients are pitifully insufficient. Plumbers, carpenters, men who labor with their hands, with a limited maximum possibility of income, pay to their organization machinery ten and fifteen times the usual dues paid to a medical organization. It is unusual in any State Society to find a per capita expense budget of more than ten cents per annum devoted to committee work, watching over the security of your investment in your education and your income.

I should like to go into the possibilities of consulting with other organizations in order to bring about a coöperation by which we may hope to control some of those social trends which are now being artificially induced, particularly by those who are employed by the foundations.

I should like to refer to the commendable example of New Jersey in writing a lien law

on the statute books to protect you when you have cared for a highway or other negligence accident and are left holding the bag.

Under the Workmen's Compensation Law this year we in New York matured our work to the point of drafting an excellent bill, only to have Christian Science written into it in order to bring about our opposition to the very bill which we had originated. That is the cleverest way, of course, of defeating a legislative measure.

In the ensuing year or more we shall undoubtedly be confronted with the old issue of *compulsory health insurance*, rehabilitated, with the stage carefully set by hundreds of arranged meetings and selected speakers developing a public understanding favorable to the introduction of socialization bills in the various States for the control of medicine, and also, as I shall try to demonstrate to you, the control of the masses through the agency of its compulsory insurance.

HEALTH FOUNDATIONS

The social and the political order of our nation and the health of its people are threatened by dynamic nonsense. There is a well planned campaign to misinform and mislead public opinion. Proponents of social experiments, aided by class-room dreams of school professors of a pseudoscience, are undertaking to overturn the sound, fundamental principles and structure of home and national life. They are utilizing the stresses and distresses and the unrest of the present era, in the effort to promote a surrender of our present individual freedom of action in the pursuit of life in return for a communal subjugation and the speculative security of collectivism.

Their schemes are dynamic because they are powerfully motivated by conscience money operating through "Foundations,"—dynamic because of the propaganda efficiency of hired publicity agents. The ideas of these agents being in the greater part illogical, unproven, or disproven, and obviously impractical when reduced from generalizations to details, are in truth "pure nonsense," unless unrevealed, ulterior purposes lie behind them. There is

reason to question the honesty of purpose of these agents when we reflect upon the point that their oft-repeated premises of alleged facts are patently untrue.

Let us pursue this line of thought for a possible clearer understanding of the motives of those who advocate "some form of health insurance for industrial workers,"—compulsory health insurance!

Bertrand Russell, writing on "Effective Intolerance," has said:

"Industrialism is synthetic; it builds up large economic units, makes society more organic, and demands suppression of individualistic impulses. . . . Undoubtedly the communist philosophy is more suited to industrialism than the philosophy of capitalism, because industrialism inevitably increases the importance of organizations as against individuals. There is an increasing tendency for the control of the sources of opinion to become concentrated in a few hands, with the result that minority opinions lose the chance of effective expression."

Catch now the thought of Matthew Josephson, picturing the rise of the leaders of industry during the last half of the past century:

"But to tell only how the captains of industry 'made themselves and the country rich' would be to leave out much of the story. We must turn aside from their purely mercenary operations to picture to ourselves for a moment how these barons of coal, iron, or pork, by a natural concomitant effort to which many interests led them and many voices called them, extended their sway throughout the social order; how . . . they overran all the existing institutions which buttress society; how they took possession of the political government, of the school, the press, the church.

"Although he plainly required neither defense nor urging, the claim was constantly made for the baron that he might rightfully take command of the popular institutions; or, as another spokesman termed it, 'without hesitation or apology assume the place to which he is entitled in commerce, or the industrial arts, in professional life or society.' So, like the landed gentry, the military chieftains, or the priestly class of old, Veblen tells us, the new captain of industry in his turn now received 'the deference of the common people,' became the 'keeper of the national integrity,' and, with a becoming gravity offered himself as philosopher and friend to mankind as 'guide to literature and art, church and State, science and education, law and morals—the standard container of the civic virtue'.

"In short order the railroad presidents, the copper barons, the big dry goods merchants, and the steel masters became Senators, ruling in the highest councils of the national government. But they also became in even greater number trustees of universities, partners or owners of newspapers or

press services, and figures of fashionable, cultured society. And through all these channels they labored to advance their policies and principles,—sometimes directly, more often with skillful indirection."

Along with the organization of medical care will develop organizations of the workers who are to be served by it, with the exercise of that control which captains of industry crave; and we shall see the dawn of the era of industrial-social slavery.

May I direct your attention to the Cleveland issue of the Journal of the American Medical Association, (May 12, 1934, page 1612), in which the Bureau of Economics of the American Medical Association has given a

concise, splendid exposition of the fallacy of insurance in medical care, showing that all the schemes of socialized medicine in Europe have originated, not from demands of the working class, but as the instruments of politicians. European experience demonstrate that the *lay management* has overgrown the *medical personnel*; that the medical care has not been advanced, and that medicine has become stagnant and incompetent.

It will be necessary for you to support your medical leaders and protect them. Stand by your leaders when they move into line to help us fight this battle against compulsory health insurance.

WEST COAST EXPERIMENTS IN PROVIDING MEDICAL SERVICE

By SETH A. BRUMM, M.D., Philadelphia, Pa.,

President-Elect of the Philadelphia County Medical Society

Abstract of an address given before the General Session of the 168th Annual Meeting of the Medical Society of New Jersey on the evening of June 5, 1934, in Atlantic City

Medical economics is a variable subject. In addition to what we ordinarily call economics, it takes in selfishness and personal aggrandizement; it takes in religion; it takes in tradition—all of which is hard to present in an analytical, logical manner.

Now, as to the definition of medical economics, I have seen none in the lexicon that is applicable as we wish to apply it today. Medical economics, as I see it, is that activity which provides for the protection and the guidance of the physician, so that he may mete out the very best type of medical practice attainable to the sick.

That, I think, is about as brief and concise a definition as I may give for medical economics.

Now, then, we have the relation of the doctor to hospitals; we have the relation of the patient to the hospital; we have the relation of the patient and doctor to the hospital; and the encroachment of lay workers, compensation acts, contracts, and different forms of insurance. There are so many items involved in the question of medical economics that it is

hard to meet all those conditions which are satisfying to the particular individual who is obsessed as to whether or not he is receiving his just deserts. The human equation must always be considered. Medical economics today is largely a matter of protection of the doctor. The subject that is paramount with us physicians today is whether we shall have the socialization of medicine or not.

ORIGIN OF SOCIALIZED MEDICINE

The socialization of medicine has never developed because of a humanitarian situation. If there was ever a deliberate, cold, concise, false movement, it is on the part of those who wish to socialize medicine.

This thing began in its modern form in 1878 to 1884, under the jurisdiction of Bismarck, who was confronted with the amalgamation of the provinces of Germany into a great German empire. Unfortunately, he had to spend money, because there were the great armies and navies to maintain, which the internal and foreign intercourse had made necessary, and which made taxation a tremendous burden upon the citizenry. Because of

this taxation the seismograph began to register the rumblings of dissent. He knew that if he were to live through the problem, he would have to do something.

What did he do? He looked about him with great acumen. Did he pick on religion or industry? No. He said, "I have got to get that item which appeals to the human soul, and carries with it a great economic relativity."

Now it may interest you ladies and gentlemen to know that in the United States of America, and in Germany, and in any other country in the civilized world, the economic position of medicine is fourth or fifth in the list of great industries.

MEDICAL BUDGETS

Do you know that the cost of medical care is larger in money turnover than the budget of the United States Government in normal times? In 1933 Ogden Mills' submission of the budget was \$3,700,000,000 to run this great country; and the money turnover in medicine, not counting the investments in bricks and mortar and hospital equipment, which were \$3,000,000,000 or more, but just the money turnover, is \$4,300,000,000. Very interesting, isn't it?

Now the check and the doublecheck on this thing is that sociologically medicine occupies the third demand on the dollar earned. That which is viable, that which comes from any biological entity, has got to have *food*. Is that right? Yes. The second thing is that it has to have *textiles* and kindred products. Therefore, we have items one and two. The third item is *medical care*.

So, it is nauseating to hear people say they haven't money to meet the medical budget. Three cents must come out of every dollar for that because economically, humanitarily, scientifically, it occupies the third position. But the American people have seen fit to budget the item of medicine at anywhere from twenty to thirty or fifty, down the line of itemization.

So when the agents of the "Health Foundations" come out and say that it is pathetic that these people are caught, that they can't possibly pay their medical budget, it is absolutely

ridiculous. Of course they cannot pay it out of their budget if they are going to pay \$676 a year for automobiles, chewing gum, radio, moving pictures, and so forth. Certainly they can't pay it, but don't say that the budget or the item for *medicine* is high. The fact of the matter is that the item of medicine is one of the very cheapest things that the human being purchases today. It costs \$150 for a family of four; that is the average, and that includes the services of the doctor, the dentist, two weeks in the hospital, and one week of nursing, and the medicine. That is the average.

I am not saying that, in sporadic instances, a given individual may not be extremely hard hit in a given year.

I have mentioned the \$670 which he sees fit to pay for pleasures which are *perverted* pleasures. It would be far better that the child of the American mother be kept out of the movies, and it would be far better if they would not listen to half the things on the radio. But when they see fit to budget that money, and then throw themselves upon the medical profession as a crutch and say that we are gouging them, it is *absolutely false*. It has no economic premise whatever.

ENGLAND

Now, then, Mr. Bismarck was the young man who began this socialization of medicine,—this juggernaut that developed and has spread over the whole continent of Europe,—and it has spread so that there is not a country in all of Europe that has not developed some form of socialization of medicine, and finally England got it. France, by the way, has had a recall.

I refer you to the Bulletin of the American Medical Association of December, 1933. The Socialist Party in England has had a recall. It costs too much money, and the medicine has been terrible. In England, what have you? They are under the leadership of whom? Is it a doctor, a minister, a man inclined in humanitarian acts? No—Lloyd George.

There is the interesting thing, as I have told you, that these men who know nothing about it are the ones to suggest and formulate this concept of taking over the practice of medicine.

Can you imagine Mr. Bismarck doing that? And now we come down to Lloyd George. They have tricked the English doctors, yet I am sorry to say that some American doctors feel that the English system is par excellence. It isn't so. They are not familiar with it.

The situation in England was that they always carried a million of indigent even in prosperity, and that medical load was thrown on the young doctor, for which he received no compensation. It was for this indigent million that the panel system in England was originally designed. But, with the acumen of the politician, together with the political and capitalistic powers, they have added five more millions of patients, and then five more millions, so that in England today you have eleven millions of people who are supposed to enjoy this form of medical insurance; and the young doctor, as he leaves his hospital or school of medicine, was offered an income of \$2,200 a year, which was quite magnanimous, even enough so he could afford a small Austen car. He felt as though Eureka and Excelsior had presented themselves, but he didn't realize he had put himself into bondage.

What has happened so far? It has all developed in the last year and a half or two years. The English scheme is that the workman pays one-third of his premium. The Government pays two-thirds of the premium, but they have five millions of people out of employment, so that means they are not able to pay the premium. Humanitarianism is cast to the wind and nobody can take care of the poor souls except the poor doctor who is doing it; but they have caught the doctor in the white collar class in the other six millions, and the English scheme is breaking as fast as it can.

ORIGIN OF SOCIALIZED MEDICINE IN AMERICA

But these reflections have passed themselves before us; and unfortunately, the skull of "Poor Yorick" is cast at our feet in this country of ours which we call the country of individualism, in which we talk of patriotism and the personal privilege. We have such synonyms as compensation insurance, and so forth,

but they are the same type in the woolsack, and now we are back to this.

One of the most interesting things is that it isn't the medical profession; it isn't ecclesiastics, and it isn't labor that receives this small pittance. There isn't one labor union—get this—in the United States of America that is asking for socialization of medicine. Does that mean anything to you? There is not one.

Then who is back of it? I have told you that this idea of socialized medicine had a great economic value. We have certain forces, and those forces are the most malicious which have accumulated ponderous wealth. We call them "Foundations." Do you realize that about twelve of these big foundations own the United States of America today, and that almost eighty per cent of the wealth of Ohio is held by three per cent of these amalgamations? That is the situation.

Why do they want it so? For two reasons. I can show you a photostatic copy which Ogden Mills sent me, showing that since 1927 over \$1,000,000,000 have been donated to various types of foundations. Why? For two reasons, as I told you.

First, all gifts to foundations are exempt from Federal taxation. These are profits, super-profits. What can we do with this money? Can we turn it into channels from which we can get a just return, as they may call it? They have given over a billion dollars. Oh, I have the treasury report, ladies and gentlemen, in photostatic form. They are exempt, as I say, from taxation.

Secondly, they subsidize foundations and promote chairs of sociology. I should like to spend the rest of the night talking to you on professors of sociology, but, to get back to these super-prophets. They say, "If we can keep the incidence of health up, without paying for it (get that—without paying for it), we will have returned to our coffers in money days so much per cent." The ordinary little two or three-day sneezy cold costs industry a half billion dollars a year. This is the point. Think those facts over, ladies and gentlemen.

Now, if they can get somebody to pay that obligation, they will begin to measure in

greater profits this money which they have diverted.

They owe to the Federal Government this money which they are giving. It is so ridiculous. I am enough of a financial man and economist to know that if they had these super-profits, they would have three possible outlets. The money should either go to Federal Government in the form of taxes or it should be prorated upon the salary of the workmen who earned it and gave it (because 75 per cent of wealth emanates from the man who works); or it should be reflected in the cheapness of the commodity. That is easy mathematics, and that is easy economics.

Oh, no! They take these super-profits and apply them for perverted purposes. That is just as true as can be. There is no other answer to it. There is no humanitarian idea or concept in this whole crusade.

THE CALIFORNIA SITUATION

I have been asked to talk on the Californian situation and, purposely and with forethought I have deviated from it. I will make only a few remarks, because it can be presented in a few words.

The Californian situation today is not complimentary to the medical profession. Its percentage of licensed physicians who are members of a county, state, and national medical society is the lowest of any State in the Union, —50 per cent.—while in New Jersey, Pennsylvania and New York the percentage is 65 per cent.

Competition is keen among the doctors of California, for the State has one licensed doctor for every 520 people. The proportion in New Jersey is one doctor in every 900 people; in Pennsylvania, one in 790; and in, New York, one in 620.

Competition among the doctors of California is not limited to their fellow practitioners, the State has licensed as many cultists as it has practitioners of scientific medicine. No wonder that the regular physicians are tempted by the prospects of immediate gain, and yield to seductive forms of socialized medicine and contract practice in order to make a living.

Contract medicine is rampant in California,

but it is run for gain. The contract men make no provision for old age, nor for juveniles. They have skimmed off the cream in industry. In all forms of socialization and insurance forms of medicine, the human being is measured up like a machine. There isn't an insurance that takes care of the children or the aged. Get that! The insurance schemes are for gain only.

California has another group, under the leadership of Dr. Crane, who is an ethical doctor and a man of much consideration. He has built up what he calls the *American Medical Protective Association*, whose membership is composed of doctors, lawyers, nurses, and decent citizens; and he has put through some magnificent legislation. He has closed up some of the contract health centers in San Francisco and gone in and beaten them at their own game, treating patients for fifty cents a visit, and he did this until so far he has closed \$3,000,000 worth of institutions whose methods were unethical.

THE SITUATION IN WASHINGTON STATE

The State of Washington was practically under the control of the lumber industry, which put in the contract form of medicine. There were twenty-five physicians who controlled this contract practice, and every young doctor who wanted to practice medicine had to apply to them and had to practice so that he split fifty-fifty. Then the depression came along, and it was a case of Joseph being sold into bondage. Industry closed and cut wages, and you have in that State one of the most deplorable conditions among young doctors in any part of the United States.

THE BONDAGE OF SOCIALIZED MEDICINE

Don't you see what I am trying to impart to you? As soon as you barter and lend yourself to the jurisdiction of the third party, the layman, you have put yourself in bondage. Even though the glitter and glow of immediate income may be coercive, you have put yourself in a position, just as they did in Washington, to be dictated to. That is all there is about the practice of medicine on the Western slope.

COMMUNISTIC MEDICINE

Now then, socialization of medicine is the communistic type of medicine. I can't believe that we have a man who has been raised under the American flag, who has had the tradition of democracy and the freedom of thought, and the expansion of rights that the American people have enjoyed, who can tolerate this. Don't you see, our social bringing up, our whole relativity is so different than that of Russia, France, England, or any other European nation? We have a different concept, a different privilege, a different personal selection of life. I can't believe that there is a doctor in the State of New Jersey who wants to practice under the realm of communism. I can't imagine it. I can't imagine it under the German situation, nor even under the English situation.

Communism is not socialism, but the term has been perverted. If you look in your lexicon, you will find that definition of socialism, "one for all and all for one," but when Mr. Stalin ruins your business, or runs your business, and my business, and everything else, you no longer have socialization, but you have bureaucracy, and specialized imperialism, a dictatorship. You see, it is anything but socialization.

When you come over to Mr. Hitler, he can license four thousand naturopaths over night and give them the same privilege as those of long training and study, the academic, scholastic type of doctor; and he can immediately stop any more research or scientific investigation. That is not socialization; that is bureaucracy of the worst type. That is imperialism, and it is the same thing in England, and the same with Mr. Mussolini, as liberal as he may be.

We have, unfortunately, mixed our terms, and these Foundations have used the word "socialization," and it is all right if it is used as a synonym for *democracy*, but we want no socialization if it is used as a synonym for *bureaucracy*.

Gentlemen, if the State of New Jersey to day should decide to go into insurance and State medicine, I ask you from the bottom of my heart, who is going to run it? Did that

ever dawn on you? Who would run the thing? Have you thought of the expense?

I told you the money turnover for medical service in the United States is \$4,300,000,000. Who is going to pay it? France soon found out, and they said stop. The Frenchmen were sick and tired of it.

FOUR QUESTIONS

When anyone talks about having insurance medicine, I have just got four little inquiries to ask. If they can decide these four questions, the medical profession of the United States will try to rearrange themselves so that they can possibly get some information for a plan which we hear so much about.

This is the first thing that we demand, and that we have always demanded;—*that the standard of medical practice shall be maintained*. Is there a doctor who disapproves of that? That is our great fight. Our whole life has shown that.

Secondly, that hospitals and physicians shall be adequately *remunerated*. We certainly believe in that, don't we?

Thirdly, that the *exact cost shall be ascertained*. We have never had any actuaries who knew the exact cost of the insurance. You can't get it. The only example we have is in Washington, D. C., where there is an insurance group, and they take an actuarial average and add 50 per cent as a safety factor on the cost of medicine. As soon as you put in the third person, you have got to run the price of the commodity up. That is just mathematics.

Fourthly, that it shall be shown definitely *how the cost shall be met*.

We are not going to have socialization of medicine. The worm is turning and the reflections from Communistic Russia, from Hitlerism, and various other individuals' "isms", are changing. There isn't a day when you read your papers that you are not told to get back to rugged *individualism*. The medical profession will allay the spectre of socialized medicine when the members develop their own *individualism* into *coöperation* with one another and with all other organizations engaged in the delivery of the services of health.

THE PHYSICIAN AND MEDICAL ECONOMICS

By EDWARD W. SPRAGUE, M.D., Newark, N. J.,

President, Essex County Medical Society

An address at the First General Session of the 168th Annual Meeting of the Medical Society of New Jersey on June 5, 1934, in Atlantic City

Several years ago I read a short statement by Dr. Lyman Abbott, in which he said that socialism might be an ideal state, but it could only be lived in by angels.

It seems to me that many of our troubles today are due to the greedy, unscrupulous, wealthy people at one extreme, and the unmoral criminal class at the other. We have a very much clouded atmosphere with theories today, but there are some actually serious conditions which are striking at the foundations of medical practice. We must be watchful.

I believe that the National Socialist Party's platform of 1912 contained some very radical planks. If you look over that platform today you will see that practically every one of those planks, with the exception of health insurance, has been incorporated in some form in our present government; and so we must be watchful.

Around us and in our midst the social revolution promises a redistribution of wealth. These revolutions eventually burn themselves out during their height of activity. However, many plans and schemes arise as panaceas. This phase comes to medical practice as well as other groups. We admit that. It is here now.

The doctor has always cared for the poor and is glad to do so. We admit that the super-added burden at this time is very great, and we welcome help in this State by the Emergency Relief Administration. However, we must scrutinize carefully the plans put forth by foundations and social workers and politicians and even statesmen. They should all be passed upon by the physicians, and by the people who are to receive this medical care.

You have read of the plans laid out here and tried there. Tonight you have heard of the very interesting conditions, the distressing West Coast activities, and a clear presentation of their pernicious trends, by Dr. Brumm.

You have heard the philosophy of the matter well and ably covered by Dr. Elliott, and our New Jersey problems adequately brought before us by our own Dr. Thomas Lewis. (Journal, July, page 00). These reports are all absorbing in interest, and deserve our thought and discussion.

Recently Mr. Harry Hopkins, the national head of the Relief Administration, one of the aces of the Administration, said this:

"I believe that health insurance is coming. This is a new day and if it were not for our own timidity, we would be much further along with it than we are now. I am convinced that with one bold stroke we could carry the American people with us not only for unemployment insurance, but for sickness and health insurance, and that it could be done in the next eighteen months, if we only had the courage to go after it and do it."

You can see what is in the minds of the nation's leaders, those in high places. What must strike you all is the lack of a thought-out course of leadership and action by our parent body. The recent issue of the American Medical Association Bulletin has laid the first sound plank of information. The profession must develop and mold out of the essential problems about us a definite way and see it through to a successful solution, or have foisted upon it schemes which strike at the very foundations of our philosophy of medical practice.

If the various plans suggested are not for the best interests of the patients and society in general (and we know they are not), then we should lay down a well thought-out, strong and forceful opposition.

Our mission is to advance science, to care for the sick and injured. Society today has deposited in our keeping that trust. Let us not betray it. Let us lead and not follow. Let us not lose our will. Let us keep the problems of medical care in the control of the physician.

ABSTRACTS OF LOCAL MEDICAL PAPERS

HEART DISEASE

By W. D. STROUD, M.D., Philadelphia, Pa.

Abstract of an address before the Cumberland County Medical Society
at Bridgeton, N. J., July 10, 1934

Physicians are inclined to be too pessimistic in regard to prognosis in heart disease. Dr. Stroud told of heart cases in which bad prognosis had been given, and advice to cease from all activities, and yet the patients had disregarded the advice and had lived normal lives for many years.

Four main causes of heart disease are now recognized:

1. Congenital.
2. Rheumatic fever (includes chorea, streptococcal infections).
3. Syphilitic.
4. Degenerative (includes hypertension and all forms of arteriosclerosis).

Diphtheria seldom does permanent damage to the heart. Its toxins may poison the heart and cause death; but if the patient lives there is apparently no resultant permanent cardiac pathology.

The toxic thyroid probably does not cause pathological changes in the heart, although it is a factor in diminishing cardiovascular efficiency through increased glycogen metabolism in the heart muscle and the additional burden placed upon the cardiovascular system through the increased metabolic rate of the entire body.

CONGENITAL HEART DISEASE

If a child with congenital heart disease lives for five to seven years, even with cyanosis, he usually does fairly well after that age. If given too hopeless a prognosis by a physician, some such cases fall into the hands of cultists who receive undeserved credit for maintaining circulatory efficiency and prolonging life.

RHEUMATIC FEVER

Rheumatic fever is the most frequent cause of heart disease in childhood and young adult life. We believe it is the cause of 90 to 98 per cent of the cases which develop before the age of 20 years. The cause of rheumatic fever is still in doubt. There seems to be a definite familial susceptibility. In streptococcal infections, the heart is the danger point. The acute effects of rheumatic fever, such as arthritis and choreiform movements, usually clear up, but it is the continuous low-grade rheumatic infection in the heart which does the damage;

hence the necessity in these cases of prolonged rest in bed and careful medical supervision for the rest of their lives. In cases in which the individual has been able to overcome the active rheumatic infection, there is of course a resultant chronic valvular lesion in the majority of cases. Too often physicians place a serious prognosis upon the resultant murmurs, thus producing an introspective psychosis in these patients, and often causing more invalidism than is produced by the heart damage itself.

THE SYPHILITIC HEART

Syphilis causes about eight per cent of the cases of heart disease, but syphilitic heart disease, we believe, is becoming less frequent, possibly owing to its earlier recognition and more thorough treatment.

THE DEGENERATIVE GROUP

Approximately only thirty per cent of those having coronary thrombosis die immediately or soon after their first attack. The others may live for many years, although, of course, subsequent attacks may occur. Nervous strain, worry and responsibility seem to contribute to the development of coronary thrombosis. The Chinese seldom suffer from hypertension or coronary disease in early or middle life, possibly due to their religion and temperament.

An essential part of the treatment of degenerative heart conditions is to work out a daily routine of life in which the patient remains relaxed and avoids nervous tension.

Digitalis, we believe, is contraindicated in cases of coronary disease without congestive heart failure. A good rule to observe is to avoid digitalis in attacks of substernal pain, in the absence of congestive failure, since it has been shown that this drug, in normal individuals, constricts the coronary arteries.

In hypertensive heart disease, sedatives are usually indicated. They may not reduce the blood pressure, but they seem to minimize the reactions of the vegetative nervous system.

Dr. Stroud quoted the saying of Dr. Osler, "The way to live a long happy life is to get a chronic disease and nurse it." This is especially applicable to heart disease. Dr. Stroud told of prominent doctors of his acquaintance

who had attacks of coronary thrombosis and yet lived active lives for years.

Never say "angina pectoris" to a patient. The word frightens them, for they have seen it often in newspaper descriptions of the sudden deaths of prominent men. In such cases, if a doctor is compelled to tell his patient the name of his disorder, why not call it "temporary anoxemia of the myocardium"?

DIET

We know little about diet in heart disease. A diet high in animal protein was formerly considered to be a factor in the cause of degenerative heart troubles and pathological con-

ditions of the kidneys, but this theory has been discredited. It is also questionable if an ordinary amount of salt in the average diet is a factor in producing high blood pressure, as was formerly supposed. Exercise in moderation is also no longer feared; it is even prescribed with good results.

The most important principle for the general practitioner to remember and apply in the treatment of a patient with a degenerative form of heart trouble is to avoid frightening the patient, but on the contrary to give him that encouragement which induces him to relax and to lead a placid life.

PEPTIC ULCER

By VICTOR KNAPP, M.D., Asbury Park, N. J.

Abstract of a paper read before the Monmouth County Medical Society in Long Branch, March 18, 1934

The cause of peptic ulcer has not been found. There are about thirty ways in which an acute ulcer can be produced in an experimental animal, but chronic peptic ulcers have never been produced consistently by any method. The experimental animal does not suffer from chronic ulcer.

Vascular damage or interference with the circulation in the mucosa stands out as the one hypothesis to which most experiments lead.

The newer knowledge of capillary circulation lends weight to this conception, for we can actually see what apparently small insults to this circulation may cause stasis and rupture in these minute vessels.

TREATMENT

It is an indisputable fact that ulcers heal, and that scores of healed ulcers are found at autopsy. We are challenged then, to cure a disease that is curable.

The treatment may be divided into the *dietary*, *medicinal*, and *surgical*.

DIETARY

The principles of diet in peptic ulcer as first stated by Abercrombie in 1828 remains unaltered. The food must be small in quantity, and of the mildest quality, consisting chiefly of farinaceous foods and milk, at the beginning of treatment.

The Sippy diet is a strict interpretation of this first diet, but there is not usually need that it be followed in all its details and restrictions. Neither is rest in bed always necessary.

Practical experience shows that most patients recover under a more liberal diet and normal activity as quickly as on a strict diet and complete rest in bed.

MEDICINAL

The indication for medicinal treatment is the control of the gastric acidity. An alkali, but not in large doses, is a standard preparation. Mucin, metaphen, and pituitary extract are some of the newer agents suggested.

Belladonna for the control of spastic phenomona is indicated.

Gastric lavage is proper in order to give the patient comfort and to keep the stomach empty within normal time limits, in pyloric stenosis.

SURGICAL

Gastrectomy is a surgical procedure sometimes advised for peptic ulcer; but the tendency now is to avoid operating except for definite indications, such as repeated bleeding, perforation, and pyloric stenosis.

Recurrences often take place even after surgical treatment. No known treatment removes the cause of the ulcer.

It is generally agreed that all ulcers should undergo not merely one but many courses of medical treatment before the patients are subjected to operation.

The question of the malignant degeneration of a peptic ulcer has never been decided. Many believe that a cancerous ulcer was malignant at its start.

ESSENTIALS IN EARLY TREATMENT OF TRAUMATIC CASES

By HARRY SUBIN, M.D., F.A.C.S., Atlantic City, N. J.

Abstract of a paper before the Staff of the Pine Rest Sanitarium, November 9, 1933.

The purpose of this paper is to re-emphasize facts already well known concerning the early management of accidental wounds. Too much emphasis cannot be placed upon the practical application of these basic principles of first aid treatment. The period of disability and the percentage of return of function are directly dependent upon the efficiency with which first aid measures are applied.

OBJECTS

Since the foremost consideration is to get the patient well in the shortest space of time, it seems almost unnecessary to repeat the necessity for using splints for infected fingers; inserting adequate drainage in scalp wounds; and the early removal of horse hair sutures.

The gravest complications occur from too much haste in closing a wound and too little thought as to the method of closure and drainage. Ever since speed has become the by-word of travel, the profession has been confronted with more and more serious types of injuries. The demand for more rapid recovery and for more complete restoration of function has become greater. Complete recovery should be sought from anatomical, functional, economic, and cosmetic points of view.

To be satisfied with a good result from only one of these viewpoints is not enough. Effort should be made to obtain recovery from all four considerations. To mothers, the functional result is of the greatest importance when dealing with her child's broken leg. To young women, the cosmetic results are frequently more desirable. From the medico-legal point of view, the anatomical result is of paramount importance. The mechanic is primarily interested in the economic result; that is to say, how soon will he be able to get back to work and will he be able to do the same work as he did before the accident.

SCALP WOUNDS

In our surgical wards we constantly see cases that have received first aid treatment, either by practicing physicians or residents in the dispensary. The accuracy with which first aid treatment is administered may be the deciding factor in rendering an injury simple or complicated, i. e., of short or long duration.

We consider injuries as involving soft structures, bony structures, or both. Of all injuries seen at the Atlantic City Hospital, the most frequent is the ordinary laceration of the scalp. It would seem that these cases should rarely, if ever, become infected. However, they do become infected entirely too often. We find such complications as abscess, cellulitis, or phlegmon of the scalp requiring incision, drainage and prolonged convalescence. There are several reasons for these subsequent infections of sutured wounds of the scalp. The first, and most important, is suturing without drainage. Every accidental wound is potentially infected regardless of the manner in which it occurred. Drainage should be instituted for at least twenty-four hours. Then, too, the drainage material may be either inefficient or insufficient.

The usual drainage material seen used for scalp wounds is rubber dam. In my own experience, I have come to consider the use of rubber dam as inadequate and attended with great risk. Rubber dam left in place for twenty-four to thirty-six hours becomes frozen tightly so that the ends of the wound are sealed by blood clot, preventing drainage, and shutting out the entrance of air. Since all wounds become swollen by reactionary hyperaemia within twenty-four hours after suturing, the tension of the wound becomes great. The rubber dam itself is compressed and flattened out against the wound edges, becoming inefficient for drainage purposes. Furthermore, if an attempt is made to remove a piece of rubber dam through a wound in which swelling and tension has occurred, the rubber

dam will frequently be torn out in two or three pieces. A piece of well vaselined gauze or four or five loops of silk-worm gut will drain scalp wounds better than any other drainage material.

Silk-worm gut is the most efficient suture material for scalp wounds. Silk-worm gut can be tied tighter than horse hair. It is better able to keep wound edges of the scalp, that are capable of great retraction because of the abundance of elastic tissue, approximated. Horse hair sutures are not capable of such strength and will frequently break, either at the time of suturing or after swelling of the wound occurs. Horse hair is readily matted down by blood clot and serum; and when it is mixed with hair follicles, it is difficult to remove, while silk-worm gut maintains its position and is very readily picked up for removal.

Large haematomas of the scalp are best treated by pressure bandages and ice. After thirty-six to forty-eight hours, however, recovery will be greatly hastened by opening these haematomas, enucleating the blood clot, and inserting a small rubber tube for twenty-four hours. If haematomas are left to be absorbed, they frequently break down with infection, producing secondary abscesses in the blood clot itself. The patient's recovery is hastened and much simplified by enucleating the blood clot rather than by waiting for absorption, thereby running the risk that pus will form in the clot at any time.

Face wounds whenever possible should be sutured with horse hair and *not* silk-worm gut. The tension of face wounds is slight and is readily sustained by horse hair. These wounds should be drained, but with only *one* or *two* strands of silk-worm gut at the most. The drains should be removed within *twenty-four hours* and the horse-hair sutures removed in *three* to *four* days. The enormous vascularity of the face makes it unnecessary to keep sutures in place any longer than four days. Healing will be rapid and scar formation will be slight when suture material of horse hair is used and removed early.

In large wounds of the scalp with considerable avulsion, it is not necessary to suture at once. Greater damage is done by hasty sutur-

ing than by delayed or secondary suturing. For example: A child having been struck by a machine and receiving a four or five-inch complete laceration of the scalp should be permitted to react sufficiently before suturing is done. In this method of treatment the wound is merely antiseptized with iodine, or alcohol, and gently packed with iodoform gauze, or vaseline gauze. Any time within twelve to twenty-four hours thereafter a secondary suturing can be done with all antiseptic precautions, with proper suture material, with proper drainage material, and a cleaner and neater approximation of the wound edges. The time is not far off when the teaching in emergency surgery will be to take time and thought in first aid rather than to hurry heedlessly, recklessly, and needlessly, with no thought except to suture wounds immediately. The repair of the wound is of much less importance than the drainage of the wound. Some men in traumatic surgery have even advocated placing sutures through the edges of the wound and not tying sutures until twenty-four hours later, doing what is spoken of as a primary-secondary suturing of wounds.

There is little danger in leaving a wound open, but there is tremendous danger in closing it too hastily and too tightly.

SERUMS

While on the subject of wounds, it is apropos to mention the use of mixed serum. Patients receiving wounds in the streets or fields should receive not only the prophylactic dose of plain bacillus tetanus antiserum but a mixed dose of gas bacillus and tetanus antiserum. In the April, 1933, issue of the New York Medical Journal and Record, Dr. Allman and the writer reported three cases in which gas bacillus infection had occurred as a result of street accidents. By culturing these wounds repeatedly we found *B. Welchii* present in large numbers. After this investigation, we began the use of mixed serum instead of plain tetanus antiserum in every case in which tetanus antiserum was indicated as a prophylactic measure. Since it has now become routine in hospital practice, it would appear to

have the same value in the practice of men who first see traumatic cases and administer first aid.

HUMAN BITES

Just recently, I have had two cases of human bites of the hand. In both cases the wounds were sutured and drained by the physician giving first aid. Both cases became infected. In one case the wound developed a fulminating infection within twelve hours. All sutures were immediately removed, and the wound welled pus. I have never seen a human bite that penetrated the layers of the skin that did not become infected. It is now my practice to cauterize these wounds with carbolic acid and alcohol, and to leave them wide open, never suturing them. Infection is certain, and the sutures will have to be removed in twenty-four hours anyhow.

THE HAND

While speaking of injuries to the hand, do not forget to apply a splint. Motion of the parts invites infection. Splinting saves many cases from spreading infection. Cicatricial contractures of the fingers and hand can and should be avoided.

There is a great deal more to be said with relation to the treatment of soft tissue injuries, but I prefer to restrict my paper to early measures of treatment only.

BONES

Passing from soft tissue to bone injury, we have for consideration in these latter cases chiefly, the prevention of deformity, the prevention of atrophy, and the early restoration of function. In order to prevent deformity, avoid unnecessary manipulation of fragments in those cases in which fracture can be determined by inspection and palpation. Exquisite localized tenderness, plus history, should be sufficient to warrant the clinical impression of fracture. If fracture is suspected, the part should be immediately and thoroughly immobilized by splinting, and no further attempt be made to determine fracture except by x-ray. No manipulation of the fragments should be done unless the patient is under suitable conditions

for complete reduction and fixation of fragments. Attempting to elicit crepitus may be not only dangerous but superfluous.

The next step in the prevention of deformities is to make certain that in the fixation appliance the hand or the foot be so fixed as to assume a natural position of rest. As for example, a fracture below the knee should be so fixed that the foot be maintained at a definite right angle. A fracture of the forearm should be so fixed that the hand be supported at the wrist. Whatever method of immobilization is used, the fingers and the toes should be left free for motion at all times. Active motion should be maintained throughout the entire period of repair. Active and passive motion should be urged as early as possible; and in all instances where plaster material can be used, it should be applied because it grants freedom of use of the entire extremity from the start. I refer particularly to moulded plasters for the upper extremity, and moulded walking plasters for the lower extremity. "Use" the part as soon after reduction as possible. This is the keynote in preventing atrophy. This is the foundation for complete and rapid restoration of function.

In treating fractures in general practice the use of plaster under proper precautionary measures will give much more success in follow-up treatment. Immediate active motion of the part is granted. Painful redressings, particularly in children, are eliminated. This type of immobilization also tends to hasten the reduction of the swelling.

A word about early reduction of fractures. If the position of the fragments can be readily determined by clinical examination, reduction should be done at once, thus avoiding increased muscle tension, extravasation of blood, and swelling of soft tissues. Whenever possible, reduce and immobilize promptly without resorting to prolonged traction. The dangers of fibrous union with fragments in poor position, of decubitus ulcers and pneumonia in the aged, and atrophy of muscles from disuse, can frequently be averted. Any of these complications delay recovery and thereby defeat our primary purpose, which is to obtain early and complete restoration of function.

STATE SOCIETY ACTIVITIES

ORGANIZED MATERNAL WELFARE WORK IN NEW JERSEY

By ARTHUR W. BINGHAM, M.D., F.A.C.S., East Orange, N. J.

Chairman, Maternal Welfare Committee, State Medical Society of New Jersey

Read at a Joint Meeting under the auspices of the New York Academy of Medicine, New York Obstetrical Society, and the Medical Society of the County of New York, March 7, 1934

Organized maternal welfare work in New Jersey was started in 1923 when the Medical Commission for Maternal Welfare of Essex County, consisting of twelve physicians, was appointed by the County Medical Society. Meetings were held each month at first, but later every second month, the detail work being carried on by various committees: prenatal, hospital, educational, follow-up, statistical, and finance.

The prenatal committee organized prenatal work in every part of Essex County, following largely the methods employed by the Maternity Center Association of New York City and the Maternity Center of the Oranges, which had been in operation for two years. Prenatal history cards were printed by the commission and distributed without cost to all physicians in the county who wished to use them.

The hospital committee checked up the work of the hospitals, inducing them to use similar record sheets so that the annual reports would be uniform. An obstetrical report is received each year by this committee from each of the leading hospitals in the county, a few small private hospitals not coöperating as yet. A summary of three years of these reports was published in the American Journal of Obstetrics and Gynecology. Directors of one hospital with 66 cesarean sections out of 900 deliveries, and those of another hospital with 44 sections out of 400 deliveries, read these reports with the result that in 1933 there were only 21 sections in the former hospital and 11 in the latter.

The educational committee has attempted to present the idea of better obstetrics to the public as well as to the physicians. Many talks have been given by leading obstetricians; and one year a drive for better obstetrics was conducted and an afternoon meeting for women was held.

The follow-up committee investigated every maternal death in Essex County, by questionnaire at first; but during the past year a paid investigator has made personal visits, using for reports the same blanks which were used in

the survey by the New York Academy of Medicine.

The commission started its work in a small way, and gradually developed it during the past 11 years as the confidence of physicians has been gained. The work is financed by the Essex County Medical Society. During the existence of the Maternal Welfare Commission, the uncorrected maternal mortality for Essex County, according to the State Board of Health, has been reduced from 6.9 to 4.4 per thousand live births, and in Newark from 7.4 to 4.5 per thousand live births.

As a result of this work in Essex County, a Maternal Welfare Committee was appointed by the State Medical Society two years ago, the object being to organize a Maternal Welfare Commission in every county. This has now been accomplished in every county in the state. The work in some counties is much more advanced than in others, but each county has its problems and time will be required to get the desired results.

The State Committee meets twice yearly with the members of the various commissions. Reports are heard from each county represented. There is also a talk by some prominent obstetrician. One meeting is held at the time of the State Society meeting at Atlantic City in June, and the other in Newark in the winter. On the whole, there has been great interest shown and we have had excellent coöperation.

In New Jersey, much of the obstetrical work is done by general practitioners, and any plan to improve obstetrics must include them. This is done by allowing them to attend cases in our best hospitals under supervision and subject to certain rules. At Orange Memorial Hospital, which takes emergency and ambulance cases as well as private cases, seventy general practitioners attended cases in 1933. There were 1045 deliveries with three maternal deaths, and only five cesarean sections. Physicians are expected to follow the regular hospital routines and the following rules are posted in each delivery room:

Consultation with one of the obstetrical staff is required in all of the following cases

- a. All prolonged labors (24 hours)
- b. Cases requiring cesarean sections
- c. Breech presentations (unless very premature)
- d. Difficult forceps cases or versions
- e. Occiput posterior presentations requiring forceps or version
- f. Other complicated cases: eclampsia, placenta previa, etc.

In some hospitals in the county the rule reads: "Consultation must be had with a qualified consultant", thus giving a little more choice.

If the general practitioners are not allowed to attend cases in our best hospitals, they are obliged to use the private nursing homes or

keep the patients at home. In neither of these places do they have any supervision, nor is it easy to get consultation without considerable trouble and expense. In the supervised hospital, consultations can be promptly given without charge unless the patient is able to pay a moderate fee.

Therefore, we recommend a sufficient number of beds in Class A hospitals where the general practitioners as well as the obstetricians may take their patients, where their work may be supervised, and where they may have the advantage of consultation in abnormal cases.

THE PHYSICIANS' LIEN LAW

The need of organized action by the physicians of New Jersey is demonstrated by the task of formulating a fee list in accordance with the provisions of the Physicians' Lien Law. There is difficulty in establishing satisfactory fee lists for the twenty-one counties of the State. Prevalent charges in individual localities must be considered, and fee lists publicly on file may be quoted to the confusion of both the doctor who charges less, and also of him who charges more in his ordinary practice. However, these considerations will not deter a county medical society from agreeing upon a list of equitable charges.

The special committee of the State Society on the Physicians' Lien Law, of which Dr. Elmer Peter Weigel, of Plainfield, Union County, is Chairman, is following the usual procedure of The Medical Society of New Jersey in developing a standard of procedures for the guidance of the committees of the County Societies. The State Committee now offers a tangible list of charges for conditions which physicians are likely to meet in their accident practice. The County Societies are expected to take this list as a model which they will change to meet their local conditions.

Copies of the suggested fee list have been sent to the Secretaries, the Presidents, and the Chairmen of the Committees of the County Societies. It is expected that every member of each county society will read the fee list,

and will express his opinion regarding its application to local conditions.

Go to your Secretary or President, and ask to see the fee list.

It is expected that the local physicians will take up the study of the list *immediately*, so that the legal organization for putting the law into effect may be completed at an early date. The advice and assistance of the State Committee is available to every County Society, and to every member; and there will be no time lost in putting the Law into effect if the local committees act with the promptness of the State Committee. The amount of time and effort which will have to be devoted to perfecting the local organizations can be given within a fortnight just as well as six months. Every week's delay will be to the disadvantage of the medical profession, and will result in a loss of the income which the law can produce.

The physicians of New Jersey have solved greater difficulties than that of agreeing upon a standard fee list; and there is no doubt that they will promptly set up schedules which will be fair to the medical profession and to those whom the physicians serve.

Although other states have tried to secure the enactment of a Physicians' Lien Act, New Jersey is the first to accomplish that object. The action of The Medical Society of New Jersey and its component county societies will be a precedent which other states will study and follow.

MEDICAL EMERGENCY RELIEF PROBLEMS

The reorganized state committee on Emergency Medical Relief finds itself quickly engaged in surmounting difficulties and furthering the organization of this work.

RIISING COSTS

The Emergency Relief Administration recently called to our attention the mounting costs of medical care to their clients and asked us to study the problem with them, to see if this expense was justified. The expenditures have climbed month by month since our agreement has been put into effect. During the thirty days of June the total costs were: medical services, \$73,454; medical supplies, \$24,704; hospitalization, \$78,232; making a total of \$176,392. That is a large sum of money for the State of New Jersey to be spending for medical care of the indigent. A year ago the state spent comparatively little directly, but probably gave modest sums indirectly as municipal aid.

We of the medical committee who have been aware of the extent of medical service to these indigents have expected that a study of costs would soon be requested. With that in view we gathered statistics as well as possible from our county committees and we have studied the trends of this work from many angles.

By and large your committee feels that the money paid to physicians represents but part value for services rendered. Few instances of overcharges by doctors have been revealed. A very few large bills have been presented and occasionally there have been bills submitted which were not above question. On the other hand, we know of untold amounts of medical service to these indigents still being performed free by the doctors. Probably only half of the doctors in the state have received any of this money. The others for various reasons carry the burden themselves. Many, many authorizations for medical care have been refused or have gone unpaid for technical reasons, even though the doctors performed the service. The exclusion of school physicians was one example, so also was the exclusion of contagious diseases.

A number of reasons for this mounting expenditure can be given:

1. We started from scratch or nothing a year ago. County after county has been slowly organized. Not until March were any expenditures listed for medical service in Newark. Previously the doctors had received nothing.

2. The number of cases on relief in the state as a whole has been increasing.

3. There has been a general tendency to shift to the state as much as possible of the local burden of relief, medical as well as food and shelter costs.

REDUCTION OF CIVIL WORKS ADMINISTRATION BILLS

We have called to the attention of the Civil Works Administration officials the action of the Washington office in arbitrarily reducing medical bills.

If we have specific complaints from doctors, we will do our best to have these bills properly adjusted. Send in any instance of reduction in your C. W. A. bill. (Page 492.)

COMMUNICABLE DISEASES

Once before we felt that proper authorizations for contagious disease care were being carried out. Yet in South Jersey particularly local relief directors were refusing authorizations for these cases.

Our insistence upon the unfairness of this ruling has brought an order from the relief council that authorizations for medical care of communicable diseases shall be approved where the facilities of contagious disease hospitals are not available.

ORGANIZATION OF THE EMERGENCY RELIEF COMMITTEE

After a conference with the old committee, Dr. Ely appointed a new and larger State Emergency Relief Committee, composed as follows:

Executive Committee:

Spencer T. Snedecor, Chairman, Hackensack

Christopher C. Beling, Newark

C. H. Schlichter, Elizabeth

E. Zeh Hawkes, Newark

George W. Fithian, Perth Amboy

Byron C. Sherman, Morristown

Lancelot Ely, Ex-officio, Somerville.

The members of this active group were selected because of their experience in the Emergency Relief work, and their geographical accessibility to Newark where frequent meetings must be held.

The other District Councilors and all the other Chairmen of County Medical Committees comprise the complete State Medical Committee. Twice a year it is hoped to convene the whole committee together at Trenton.

SPENCER T. SNEDECOR,
Chairman.

THE CIVIL WORKS ADMINISTRATION

Physicians will be interested in the following letter of explanation which has been sent out by the Civil Works Administration:

"The following circular letter has been received from the United States Employee's Compensation Commission and is for your information:

"A certain amount of delay in the settlement of vouchers for medical services rendered injured employees of the Civil Works Administration is unavoidable. Legislation extending compensation benefits to these employees was not approved until February 15 1934, and the Commission has had to engage personnel and set up its organization to handle the large volume of additional work which is involved in the settlement of claims arising out of Civil Works employment.

"Before approving vouchers for medical services, it is necessary for the Commission to have received from the local Civil Works Administrators complete reports relating to the injury of the employee concerned. Since the

entire work program was organized very quickly, some localities were slow in setting up the necessary local administration to take care of injury reports, and due to unfamiliarity of the personnel with the requirements and procedure, many reports of injury have been incorrectly filed, necessitating correspondence to obtain the information which was lacking.

"In view of the problem presented, the Commission bespeaks the patience of physicians and others who have bills for medical services pending. Every possible effort is being made by the Commission to speed up the work of examining and certifying these claims for payment, and it is believed that within a short time considerable progress will be made in further expediting these payments.

U. S. EMPLOYEES' COMPENSATION

COMMISSION

Very truly yours,

E. O. ALLARD, *Manager*,

Compensation and Insurance Division."

FORMS OF CERTIFICATION

Since the money paid for emergency medical relief comes from a public fund, a strict accounting for it must be made by the physicians, in accordance with rules established by the relief officials. Doctors emphasize *quality of service*, while administrators of the funds emphasize *accountability* along lines with which the doctor is unfamiliar. But the doctor always shows a reasonable attitude when the necessity for filling out the forms is explained to him.

Physicians have not been in sympathy with the rule that home visits shall be as few as possible; and that when a patient is visited in his home, the doctor shall certify the need that he go to the patient instead of the patient coming to his office. But every bill must pass through a long chain of accountants whose only evidence is the statement of money due.

The Advisory Committee of the Mercer County Medical Society has printed and distributed certification slips for the doctors' use.

The first slip is a notification to the doctor, and reads as follows:

State of New Jersey

EMERGENCY RELIEF ADMINISTRATION

"I hereby certify that the home visits called for on the attached bill were necessary. And I further certify that if the patient had been called on to report to my office for treatment rather than at home, it would have been against my best medical judgment."

Doctor's Signature

The second slip is to be attached to each bill for a home call and is as follows:

State of New Jersey

EMERGENCY RELIEF ADMINISTRATION

"We wish to call your attention to the fact that home visits are only to be made when, in the judgment of the doctor, a visit to his office would be detrimental to the health of the patient. And when your bill is submitted for payment, we shall desire a certification to the effect that all home visits billed for were necessary, and that in your estimation if the client had been called on to come to your office it would have been against your best judgment."

The slips lighten the work of certification, and also serve to remind the doctor of the need of the statement.

COUNTY SOCIETY REPORTS

CUMBERLAND COUNTY

The *Cumberland County Medical Society* held a meeting on the afternoon of July 10, 1934, the members being the guests of Dr. Reba Lloyd, an active member of the Society, at her sanatorium, Ivy Manor, in a suburb of Bridgeton. The invited guests also included members of the medical societies of Salem and Gloucester counties. The Medical Society of New Jersey was represented by Dr. J. B. Morrison, Secretary; Dr. LeRoy A. Wilkes, Executive Secretary, and Dr. Frank Overton, Editor of the State Journal. The Superintendents of the Bridgeton, Millville, Vineland and Salem Hospitals were also present.

About fifty members and guests were present at the meeting and at a social supper which was served at the close of the session.

The Welfare Committee reported on the good results of the coöperation of the many doctors in administering diphtheria toxoid to the school children. Dr. Knight discussed the provisions in the enacted Bill providing free toxoid and vaccines in the Clinic Hour.

The Committee to Formulate Fees in the county, provided for in the Hospital Lien Bill, is composed of Drs. M. F. Sewall, Dare Woodruff, and Frank Sheppard.

Dr. J. B. Morrison gave an optimistic account of the stewardship of the State Society during the past year. The membership of the Society has doubled in the last twenty years. The sum of \$800.00 was saved by the reduction of expenses at the last meeting of the State Society at Atlantic City. The length of the session was cut one day. The State dues have been kept at \$13.00.

A resolution was passed thanking Senator LeRoy W. Loder and D. V. Aitken, Assemblyman, for the help they had given in passing medical legislation.

The dinner dance party was a great success; and this, with previous parties, has increased the social contacts of the doctors, their wives and many of the nurses.

The scientific address was given by Dr. W. D. Stroud, of Philadelphia, Pa., who discussed the timely topic of "Heart Disease" in a most practical and interesting manner. (An abstract of Dr. Stroud's paper appears on page 484 of this Journal—Editor.)

HUNTERDON COUNTY

The regular Summer Meeting of the *Hunterdon County Medical Society* was held on July 24, at the New Jersey Tuberculosis Sanatorium, Glen Gardner, N. J. Those present were Drs. Harner, Baker, Thomas, Fuhrmann, Coleman, Closson, Tompkins, Fulper, Boothby, Gramsch, English and Love.

The visitors included the following representatives from the State Medical Society:

Dr. Lancelot Ely, President
Dr. J. B. Morrison, Secretary
Dr. LeRoy A. Wilkes, Executive Secretary
Dr. Frank Overton, Editor
Dr. F. G. Scammell, Councilor, Third District.

Dr. W. J. Crooks made application for admission.

Dr. Coleman, of the Public Health Committee, proposed that since there are no hospitals in this county, the materials for diphtheria and smallpox immunization should be kept at the three state institutions—the Clinton Reformatory, the Annandale Reformatory, and the New Jersey Tuberculosis Sanatorium.

Dr. A. H. Coleman also asked the doctors to furnish him with a list of all those who are willing to give immunizations under the "Public Health Hour" and to include the regular days and hours which they would set aside for that purpose. When this list is compiled, it will be sent to Dr. Wilkes, Executive Secretary, in Trenton, for file in the office of the State Society.

Dr. Coleman reported progress in the Post-Graduate courses.

Dr. S. B. English, Superintendent of the Sanatorium, spoke regarding the series of tests which are being conducted in the schools of the county in order to discover cases of tuberculosis among the pupils.

Dr. Ely spoke on the major activities of the State Medical Societies particularly in the Emergency Relief Administration and said that \$73,000 was paid to the doctors of the State for E. R. A. relief, of which \$213 went to the physicians of Hunterdon County. It was reported that chiropractors were asking to have E. R. A. work referred to them.

Dr. Morrison spoke on the doubling of membership by the State Society during the last fifteen years, and on the amount of money brought to the physicians as the result of the activities of the State Society. He also mentioned an organization of physicians, dentists, and pharmacists of Essex County in which 11,000 voters are enrolled for the purpose of promoting public health legislation.

Dr. LeRoy A. Wilkes spoke on the coördination of the work of the county societies according to the standards of the State Society. He stated the principle that public health projects in counties should be under the direction of the county medical societies rather than individual doctors; and that the lay organizations should seek the advice and approval of the county societies in planning their campaigns.

Dr. Scammell spoke on the political power of the physicians when they work together to attain success in public health work.

Dr. Overton spoke on the need of preserving a record of the activities of the county societies; for those of New Jersey rank among the highest in the nation.

The scientific program consisted of a talk by Dr. Max Gross, of the Sanatorium Staff, on adult forms of childhood tuberculosis and a display of x-ray plates showing the results of pneumothorax in cases of advanced childhood tuberculosis. (See article on page 445.)

WOMAN'S AUXILIARY

ANNUAL REPORTS

A feature of the 1934 Annual Meeting of the Woman's Auxiliary to the Medical Society of New Jersey was the reports of Auxiliaries of the several counties. It has seemed best that these reports should be printed in the Auxiliary Department of the Journal where the descriptions of the local meetings are placed. The official report of the State Auxiliary appears in the "Transactions" of the State Medical Society, which is issued as a supplement to this (August) issue of the Journal.

The reports of the chairmen of the committees of the State Auxiliary contained much detailed information regarding the work of the local Auxiliaries. The Secretaries of several County Auxiliaries also sent reports to their State officers in May and early June and made supplementary reports at the State Meeting. The items of information contained in all these reports have been collated and are printed in the following paragraphs in a concise form, available for easy reference and preservation.

ATLANTIC COUNTY

An Emergency Relief Committee was established to aid children or aged people and provide ten dollars to cover a period of a month for any relief they might need.

A suggestion was made to have the doctors' samples of Baby Food and Cod-Liver Oil sent to the Day Nursery.

Christmas donations were sent to the Betty Bacharach Home, Pine Rest, Municipal Hospital, Welfare Bureau, and the Pleasantville Red Cross. Although greatly reduced, each donation was most gratefully received.

A widow of an Atlantic City physician was given aid until her first salary as a C. W. A. worker was received.

In February a benefit card party was given which yielded considerable profit.

BERGEN COUNTY

The Auxiliary has held regular monthly meetings each of which had an educational program as well as a business meeting.

Some of the topics discussed were as follows:

To Dine or Diet

The Progressive Mid-Wife

The Public Health Aspect of Diphtheria
Prevention and Control of Venereal Disease

Experiences in the Belgian Congo

Newer Things in Nutrition

This Over-Sexed World.

This year a philanthropic fund was started to be used for the families of needy physicians at the call of our Medical Society.

An innovation was a raffle at each meeting. Some inexpensive article is raffled and the winner of it donates the next article to be raffled at the following meeting. The money thus realized goes into the philanthropic fund.

During the year at the request of the State Medical Society, telegrams and letters were sent to the Assemblymen and Senators urging the passing of the "Doctors' Title Bill" and "Pure Food and Drug Bills".

The Public Relations Committee sponsored an essay contest for which two prizes, one of \$10 and a second of \$5, were given for the best 150-word essay on the topic "Diphtheria Immunization to Promote Public Health". Through the coöperation of the Bergen County Chamber of Commerce and the courtesy of radio station WOR, the winning essays were read over the radio, the prizes were awarded by the President of the Medical Society, Dr. Frederic J. Quigley, who gave a resumé of the activities of the State Society in this Diphtheria Campaign.

BURLINGTON COUNTY

Sociability has been emphasized, and ten subscriptions to Hygeia have been secured.

On September 20th a luncheon was held at Mir-A meeting is held each month, with an average of the Epileptic Colony at New Lisbon.

On December 13th a tea was held at the home of Mrs. J. Howard Hornberger at Roebling, and plans were made for the annual Christmas celebration at the County Hospital.

On March 7th Mrs. Harry V. Hubbard, State President, was entertained at luncheon at Bozwood Lodge, Lumberton, and a short musicale was held.

On May 2nd the Annual Reciprocity Tea was held in the Moorestown Community House, 150 guests from other woman's organizations being present. A talk was given on "Communicable Diseases and Their Control".

ESSEX COUNTY

The Essex County Auxiliary had an active year. In the early Fall a meeting was held with the Advisory Council regarding the relations of the State Auxiliary.

The Medical Society President met with the Executive Committee to outline a progressive co-operative program in order to develop a closer bond with the County Medical Society.

The Scholarship Fund of the Society was changed to a Medical Benevolent Fund. Five hundred dol-

lars were donated to the Essex County Medical Relief Fund.

The Committees on Public Health and Public Relations functioned actively and rendered interesting reports on public health activities done by twenty-six lay health organizations.

Educational lectures have stimulated an interest in Auxiliary work.

A suggestion for next year is a membership drive with enthusiastic Auxiliary members making a personal call on eligible members who do not know of the many interesting activities of the Auxiliary.

HUDSON COUNTY

The Woman's Auxiliary to the Hudson County Medical Society has 117 members, an increase of 17 over last year.

A meeting is held each month, with an average attendance of thirty-eight members. Programs have included health subjects, such as charity, radio programs; the furthering of the outlined program. A speaker has been present at each meeting. Social activities have consisted of two card parties, a Christmas party and a Spring luncheon and bridge.

Charity has been dispensed for rent, food, and coal for needy private cases.

Dr. Quigley, President of the State Society, was the speaker at the first meeting. He described the way in which the Auxiliary can help the Medical Society.

In November, Dr. Charles B. Kelley gave a talk on "State Licensure of Physicians".

In December, a home talent Christmas party was held, with vocal and instrumental music; and also a review of Dickens' Christmas Carol, given by ex-President Mrs. John Nevin.

In January the Auxiliary and Welfare Societies were addressed by Miss Martha A. Bonham of the New York Foundling Society.

In February, Dr. Edw. Berman, Principal of the Junior High Vocational School for Boys in Bayonne, told of his work.

At the March meeting, Mr. William G. Christy spoke on "Smoke Abatement" in regard to health.

The April speaker was Governor A. Harry Moore, who told how the sick of the state are cared for.

In May Dr. B. T. D. Schwarz described the Widows' and Orphans' Fund.

MERCER COUNTY

The Mercer County Auxiliary held four regular meetings during the year.

The Fall meeting was preceded by an Executive Board Meeting.

It entertained the State officers in January, and its Spring meeting was preceded by a luncheon.

The meetings have been noted for sociability.

MONMOUTH COUNTY

The Monmouth County Auxiliary started the year 1933-1934 with 40 members; and 24 were added during the year.

Two luncheon meetings have been held at which committee work was planned and discussed.

The Auxiliary sponsored a project for supplying a nurse to the widow of a physician.

The program for the mid-winter meeting consisted of a description of the social service work in the County.

The members of the Auxiliary have been active in educating the legislators regarding medical bills.

OCEAN COUNTY

The Auxiliary has achieved a new lease of life through the activities of a few leaders in the organization.

Hygeia has been donated to seven schools which had not previously had it. The Auxiliary has given \$10 toward a much needed instrument at the Paul Kimball Hospital; and sent letters to our Senators and Congressmen in regard to Bill 183.

A public health program was initiated, the aim being to contact with the various health organizations in the County so that approach will be made easy when a new project is attempted.

PASSAIC COUNTY

Four regular meetings and one public health meeting were held during the year.

The chief objective for this year was the arousing of public interest in the necessity for health examination of the pre-school age child. Dr. Julius Levy, head of the Child Hygiene Department of the New Jersey State Board of Health, presented the subject.

Public support was enlisted in support of the Tugwell Bill. An open meeting was held at which Professor Ira D. Garod, of the New Jersey State College for Women, gave a talk on the National Food and Drug regulations as they exist and as they will be controlled under the Copeland-Tugwell Bill.

Membership has been increased and a friendly spirit created among Auxiliary members.

Suggestions for next year include the extension of the examinations of pre-school children; and securing new members for the Widows' and Orphans' Society.

SOMERSET COUNTY

The Woman's Auxiliary to the Somerset County Medical Society holds bi-monthly meetings at the same time as the County Society. October meetings are held with the County Society, the members of the Auxiliary being at dinner.

In December, Mrs. Renner gave an excellent report of the work at Skillman Village.

In February Mrs. Hubbard was the guest speaker.

In April, the Auxiliary arranged a trip to and through the Walker-Gordon Milk Plant in Plainsboro, with the members of the County Society as guests for the trip.

A new member is over ninety years old and is the widow of a physician and the mother of another.

Hygeia subscriptions have been renewed to High Schools and the County Library.

UNION COUNTY

The first regular meeting of the Auxiliary was held in October in Plainfield at the home of Mrs. Hubbard; the next in February at Mrs. Schlichter's home, in Elizabeth; and the final meeting of the year, in Plainfield, in the Nurses' Home of Muhlenberg Hospital.

In November a benefit party was conducted in the home of the President to raise money toward our scholarship fund. A benefit bridge-luncheon was held in Plainfield at the Clara Louise Tea Room, and the money was given for subscriptions to Hygeia for educational work in the high schools of the County.

COMMENT

The number and variety in the activities of the Auxiliaries recorded in the reports give one an impression of indefiniteness in the objects and aims of the organization. A common object is *sociability*; but this object is often emphasized for its own sake rather than as a means of inspiration to action.

The reports also give the impression that the members of the Auxiliaries are earnestly seeking a public health project for which their organization is peculiarly well adapted. This project must be one in which the medical profession is interested. In the absence of a well-defined project of medical relations, it is not surprising that the Secretary of one County Auxiliary reported:

"The County Medical Society sees no reason for the Auxiliary doing any definite work, but will cooperate when necessary."

There is no doubt but that the Society would welcome the aid of the Auxiliary if it were developed along practical lines, as in Essex County.

An officer of another County Auxiliary wrote:

"The Advisory Board of doctors advised the President to keep the Auxiliary a social organization, and not to interfere with the Medical Society."

A probable explanation of this criticism is that the Auxiliary may have been working with lay organizations in projects in which the doctors were not being consulted. The undeveloped opportunity for which the Auxiliary is seeking may be that of bringing about a coöperation between the medical profession of a community with its lay health organizations, as is proposed in an editorial on page 441.

SOCIETY FOR THE RELIEF OF THE WIDOWS AND ORPHANS OF MEDICAL MEN OF NEW JERSEY

The fifty-second Annual Report of the *Society for the Relief of the Widows and Orphans of Medical Men of New Jersey* has just been issued as a sixteen-page pamphlet. The Society has 516 members, most of whom live in Newark, or its vicinity. Its President for twenty-one years has been Dr. Edward J. Ill, of Newark, whose eightieth birthday was celebrated by a public meeting in the Newark Academy of Medicine, as described in the June Journal.

The report shows that the finances of the Society are in good shape. The Society has a per-

manent fund of \$52,185.92 which now yields an annual income of \$1783.86. The amount received during the year from interest, initiation fees and assessments was \$8995.25. Claims of \$5496.00 were paid.

The roster of officers and members, which is printed with the report, is evidence of the solvency and reliability of the Society.

The promotion of the Society is one of the major activities of the Woman's Auxiliary to the Medical Society of New Jersey, it having a special committee for that purpose, with Mrs. Theodor Teimer, Newark, Chairman.

OBITUARY

CHURCHILL C. FRANKLIN, M.D.

Dr. Churchill C. Franklin, a general practitioner in Trenton and a member of the Mercer County Medical Society, died on July 18, 1934, aged 37 years. Dr. Franklin was born in Jersey City and received his A.B. degree from Rutgers University after an interruption of his studies to serve overseas in the World War in the Medical Department of the Army. He graduated in medicine in the Harvard Medical School in 1926 and had practiced medicine in Trenton since 1928.

BENJAMIN F. GUTMANN, M.D.

Dr. Benjamin F. Gutmann, a leading internist of New Brunswick, died in the Middlesex General Hospital on August 7, 1934, aged 56 years. He was a native of South Amboy, and graduated from the Jefferson Medical College. He was active on the staffs of the local hospitals, and in the medical societies of both local and state. Dr. Gutmann took a prominent part in the civic affairs of New Brunswick and was held in high respect by his townspeople as well as his medical colleagues.

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*Director of the Mountainside Hospital
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NEW JERSEY DOCTORS AS OFFICERS OF THE AMERICAN MEDICAL ASSOCIATION

The May *Journal of the Indiana State Medical Association* contains an elaborate full-page table showing the distribution of the officers of the American Medical Association, both elective and appointive, among the several states during the ten-year period 1924-1933. The summary is as follows:

Illinois	212
Connecticut	71
New York	65
Ohio	51
Massachusetts	49
District of Columbia	39
Minnesota	36
Michigan	34
Pennsylvania	30
Maryland	21
Wisconsin	20
Missouri	16
California	14
Colorado	14
Indiana	13
Louisiana	13
Oregon	13
Alabama	11
Georgia	11
Tennessee	10
Nebraska	9
Iowa	8
Kansas	8
Texas	8
Virginia	7

Kentucky	2
New Jersey	1
Washington	1
Rest of the states	0

It will be seen that New Jersey has had one officer of the national society during the last ten years. Possibly New Jersey could have secured more officers and more influence if the State sought for representation.

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Located on the ground floor of the Hall of Science, the exhibit of Merck & Co., Inc., depicts the progress made in chemistry during the past century. It is situated between the chemical group in which the display of Union Carbide & Chemical Company is outstanding and the purely medical group.

Attracting most attention in the Merck exhibit is the Nososcope—a stereopticon through which can be seen something of the history and progress of diseases. It briefly depicts the constant battle being waged by science against disease. By actual count, 99 persons used the Nososcope in 10 minutes.

A pharmacy desk with a professional pharmacist in attendance is likewise attracting considerable attention. In the presence of the onlookers the pharmacist demonstrates the art of his profession in the preparation of pills, the weighing of very small quantities of powders, the filling of capsules and the preparation of other types of pharmaceutical products required in prescriptions.

Nine foot prisms of plate glass, which typify the mass of chemicals that are used today in science and industry, form a part of the outside wall of the exhibit. Selected for their brilliance and color, they attract considerable attention.

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Adjacent to the Diorama are cut-out pictures of an ancient pharmacy of the Seventeenth Century and the old factory of the Powers & Weightman Company built in the early 1850's at the East Falls of the Schuylkill near Philadelphia.

These 3 representations illustrate the marked advance in the buildings and equipment of chemical plants in the last hundred or two years.

Along the west wall stands a museum case containing interesting relics of 250 years of pharmacy and chemistry in the service of Merck & Co., Inc., and their predecessors.

Flanking the museum case are to the north displayed a part of the group of rare alkaloids which are made in the company's factories, drugs essential to the practice of medicine and useful in the arts. On the south, an arrangement of trade packages of narcotic drugs, derivatives of opium and coca leaves with models of characteristic types of opium, Turkish, Yugoslavian and Persian. In conformance with the Federal Narcotic Law the models of opium are fabricated to resemble the genuine crude opium. The trade packages are shown without contents.

For its historic value, a model of the Merck Pavilion at the Columbian Exposition in 1893 is also shown.

The shelves of bottled chemicals on the east and north sides of the exhibit are representative of the extensive line of chemical products manufactured and sold by Merck. Nearly 900 different forms and kinds of chemicals make up this display yet leave many to be accounted for in the alkaloid and the narcotic cases and still greater numbers which because of their nature do not lend themselves to exhibition.

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SEPTEMBER, 1934

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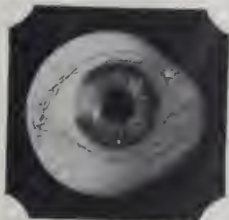
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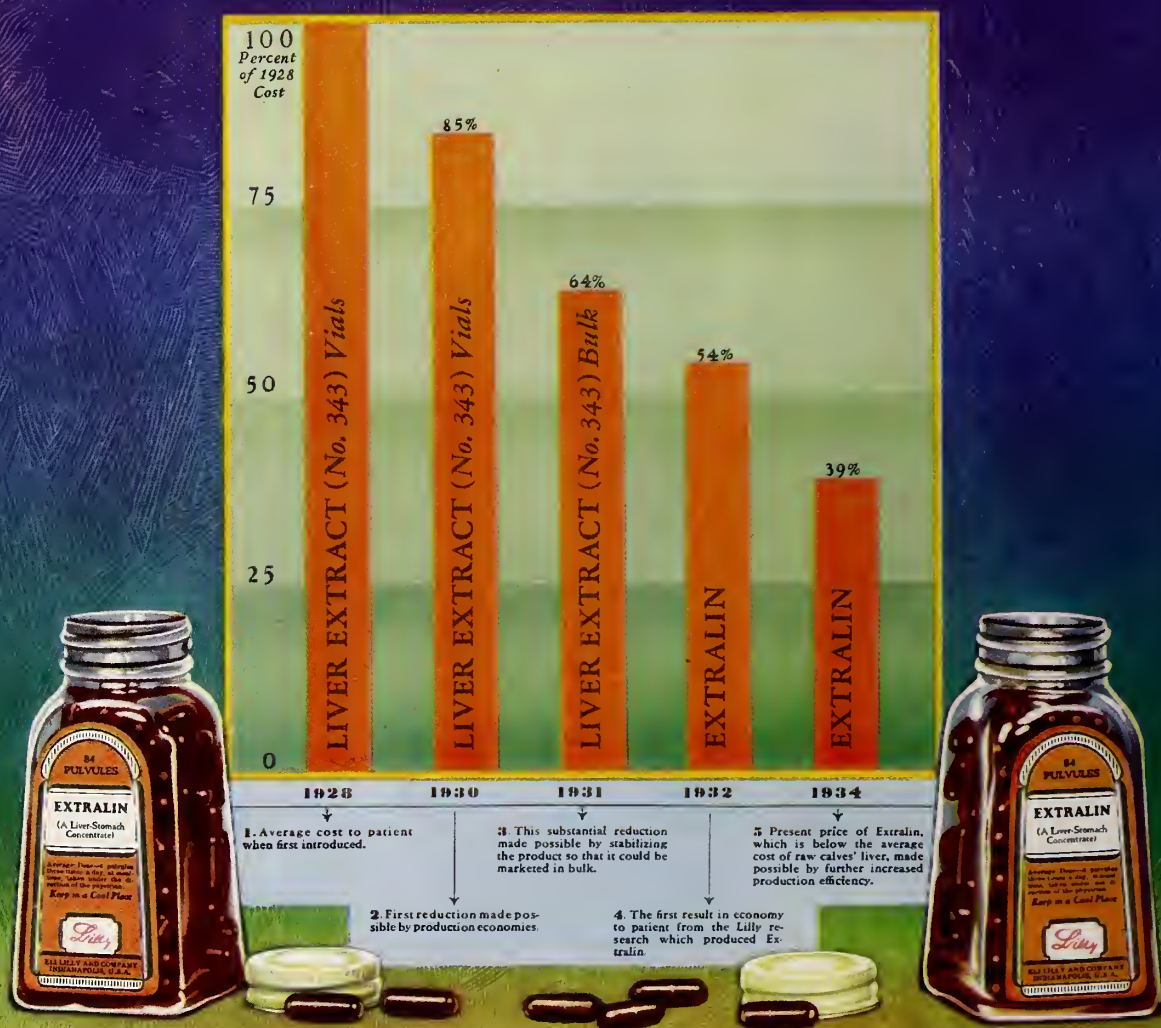
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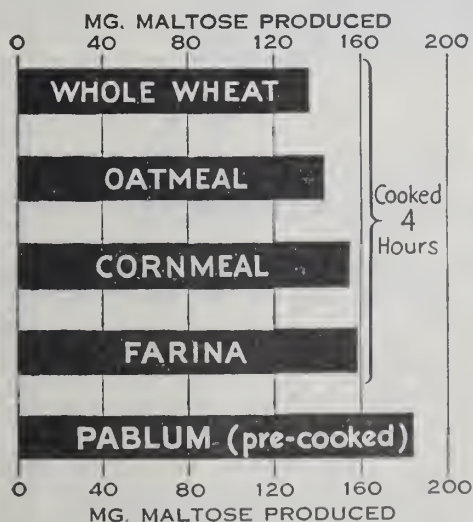
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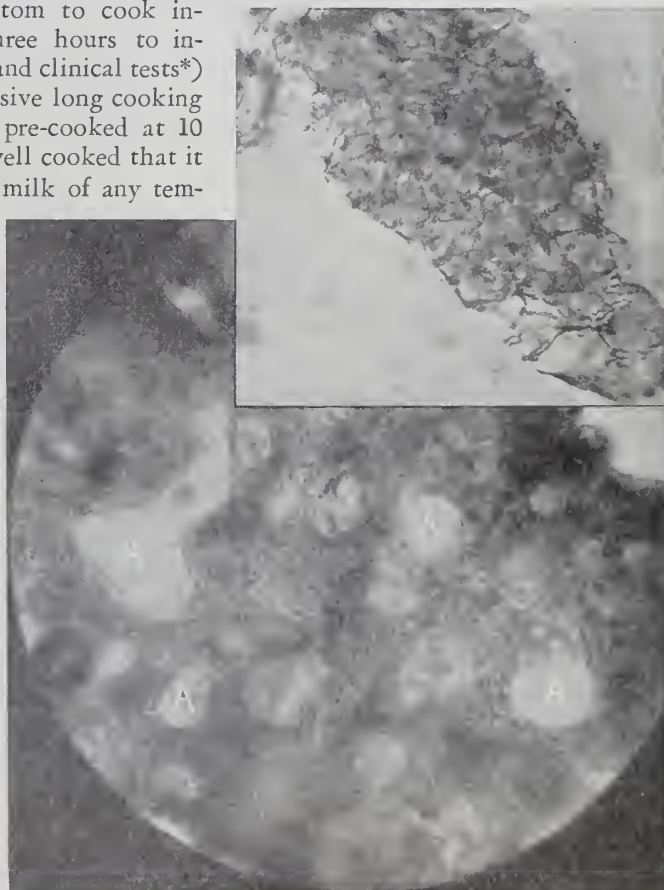
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*Chart shows that maltose production is much greater for Pablum prepared with cold water than for other cereals cooked 4 hours. Ross and Burrill (Journal of Pediatrics, May 1934) conclude from this and from the total soluble carbohydrate formed that starch digestion of Pablum is more rapid than that of 6 other cereals.



140 X, STAINED

(INSET) 290 X, STAINED

Large photomicrograph: Pablum mixed with cold water—portion of large flake. Pablum flakes are honeycombed with "pores" or air-spaces (note light areas A). This porosity permits ready absorption of digestive fluids by the entire flake. No starch granules are visible—they have been completely ruptured.

Inset: Farina cooked ½ hour—clump of cereal composed of unruptured starch granules. Note density of clump and lack of porosity. Many starch granules, such as are present in raw cereal, remain unchanged in form.

BESIDES being thoroughly cooked and readily digestible, Pablum supplies essential vitamins and minerals, especially vitamins A, B, E, and G, and calcium, phosphorus, iron, and copper. It is a palatable cereal consisting of wheatmeal, oatmeal, cornmeal, wheat embryo, alfalfa leaf, beef bone, brewers' yeast, and salt.

*Reprint of Ross and Burrill paper sent on request of physicians.

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



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Each member of the State Society is entitled to receive a copy of THE JOURNAL every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.

Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.

Officers, Trustees, Councilors and Committees of the Society are listed on page xx of the Advertising Section.

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EDITORIALS

Reports of County Society Meetings

The Journal has always carried a department of county society proceedings as an essential feature, and the county societies have responded well through their reporters. The system of reporters dates back to volume one of The Journal in 1904, the first mention of them being in number 4 (December) in the reports of the counties of Camden, E. B. Sharp, reporter; Hunterdon, Leon T. Salmon, reporter; and Ocean, W. G. Schauffler, reporter.

A list of the County Society reporters first appears in The Journal of June 1907, along with that of the Presidents and Secretaries, in the exact form in which it appears today, even to the note underneath it.

The last page of the 1934 "Transactions" lists the times of the regular meetings of the County Societies for the year 1933-34, 137 in number, of which 104, or 77 per cent, were reported in The Journal. In addition, the reporters sent accounts of the meetings of 31 other medical organizations in which the members of the county societies were interested and took part. These two series of reports filled 84 pages of The Journal.

Starting with the April, 1934, issue. The Journal began the publication of abstracts of

county society papers of general interest in a separate department, 22 pages being published.

The Journal has, therefore, published a total of 106 pages of County Society reports, or about 14 per cent of its reading matter. This proportion had not been designed or anticipated, but it developed naturally in accordance with desires and responsiveness of the local societies.

The County Medical Societies will resume their regular meetings after the summer's vacation, beginning with Bergen on September eleventh and ending with Hunterdon on the twenty-third of July. The Journal is reserving a space for a report of every one of the meetings, and will publish it promptly in a form which will be attractive as well as informative.

The proceedings of all County Societies are of equal importance. Their appeal is not merely transient and local. They have a permanent value which will be of increasing importance with the expansion of the activities of the societies to meet the modern demands for medical service. The reporters are to be congratulated on their excellent reports and encouraged to provide wide recognition for the work of the members of their local societies.

Committee on Professional Guidance

Training for the practice of medicine is along two lines:

1. The scientific principles of medicine and surgery.

2. The personal relations of the physician to his patients, his colleagues, and the community.

A century and a half ago when medical training was a four-year apprenticeship to a practitioner of medicine, the student received as much instruction in his personal relations as in scientific medicine. When the medical school assumed the sole responsibility for teaching the science of medicine, it left the branch of personal relations to the private practitioner who was formally registered as the *preceptor* of the student, and was expected to instruct him in the ethics and economics of the profession. But since the preceptor had no definite duties and served voluntarily, the system fell into disuse and was abandoned about the year 1890.

No organized system of teaching the personal relations of physicians was substituted in place of the preceptor system except the adoption of codes of ethics and fee lists. But in recent years the business relations of medical practitioners to boards of health, welfare organizations, industrial corporations, and other community groups have grown to such an extent that doctors are compelled to give attention to their personal relations with not only their sick patients but also the lay groups who assume a responsibility for providing medical care to many classes besides the sick. The medical societies have therefore set up standards of ethics and economics, and the means for enforcing them.

The County Medical Society today is a graduate medical school having ethics and economics as major courses which are of equal importance with its programs and lectures in scientific medicine.

Not only does the medical society teach the principles of personal relations, but it encourages research and experimentation to test the values of new social contacts and to develop

those which are promising. Every business meeting of a county society is a class in applied ethics and economics.

To the interne just entering upon an independent practice the County Medical Society offers all the associations and opportunities of the medical school. It is the doctor's fraternity with more secrets and confidences and more sincere friendliness than any club. It provides paternal counsel and advice to the inexperienced, and defense when he is threatened with a malpractice suit. The knowledge of his personal relations, which the young practitioner of a century ago got from his preceptor, the ex-interne of the present day must obtain from his County Medical Society, or else remain ignorant of their principles. The system is that the interne shall progress into the county society as naturally as he entered the hospital after his course in the medical college.

The June 1929 issue of the Wisconsin Medical Journal commends the Medical School of the University of Wisconsin in requiring every senior student to spend three months in the private office of a practitioner of medicine who shall act as his intimate preceptor, teaching the student his contacts with patients and the problems of the homes of the sick.

The leaders of the County Medical Societies are realizing the importance of instructing their members regarding the benefits and opportunities offered by the societies. The Medical Society of the County of Kings (Brooklyn, N. Y.) has a committee on "Professional Guidance", whose work is described in the August issue of the monthly Bulletin of the society. The article states that the purpose of the committee is "to meet young practitioners and to act as guides and sponsors for them and as counselors in their problems".

The Hudson County Medical Society two years ago entertained the thirty-one new members who had joined during the year with a dinner at which medical leaders addressed the guests on their duties and opportunities. The society thereby set a worthy example for the other county societies of New Jersey to emulate.

Quality of a Medical Society Meeting

When we studied grammar, we were taught that adjectives have three degrees of comparison. If a thing is *good*, many others may be *better*, and one the *best* of all.

A quality is a relative characteristic, and its measure is the contrast which it bears to its opposite. Goodness exists in contrast with badness; and between the two qualities there is a theoretical point at which there is neither goodness nor badness, but neutrality. As the quality of goodness diminishes, it fades out altogether, and then comes badness in increasing degree.

A quality that is ascribed to a medical society meeting may exist in three degrees: 1, that denoting positive goodness; 2, that expressing neutrality or a state of indifference to the equality; and 3, that indicating active badness. Medical society meetings are often described by the following fifty adjectives, which are listed with their negatives and their antonyms:

active	deliberate	slow
adaptive	formal	individualistic
alert	sluggish	dense
alive	inert	dead
animated	serious	drowsy
attentive	wandering	listless
best	common	worst
brief	verbose	tedious
bright	dull	stupid
brilliant	showy	commonplace
broadminded	narrow	prejudiced
cheerful	morose	quarrelsome
clear	illogical	confused
clever	awkward	bungling
colorful	drab	dark
coöperative	indifferent	destructive
courteous	strong-minded	rude
eager	apathetic	cold
easy	hesitating	perplexed
efficient	feeble	wasted
excellent	poor	rotten
fine	ordinary	punk
friendly	offish	high-hatted
good	poor	harmful
grand	paltry	inferior
honest	shrewd	tricky
inspiring	dull	depressing
interesting	dry	boresome
lively	quiet	lazy
novel	recent	antiquated
open	crafty	deceitful
optimistic	hopeful	pessimistic
original	copied	fossilized
perfect	incomplete	futile
pointed	vague	ambiguous

positive	uncertain	vacillating
practical	theoretical	visionary
prepared	extempore	offhand
progressive	time-serving	backward
prompt	dilatory	late
responsive	cold	obstructive
satisfactory	disappointing	useless
scientific	popular	nonsensical
snappy	poky	dragging
timely	obsolete	stale
united	split	conflicting
up-to-date	hide-bound	reactionary
wide-awake	sleepy	inanimate
wise	thoughtless	foolish
witty	trite	stolid

This is a formidable list of qualities to be promoted or corrected by the officers of a County Society. The most practical way in which they can improve the meetings is to do as Benjamin Franklin did when he was a young man—choose a quality for special practice on one day, and another quality on the next, and so on through the list of desirable attributes.

The President of a medical society may choose as a starter the antonyms *prompt*, *dilatory* and *late* and their associated triad, *snappy*, *poky* and *dragging*. These qualities are of special importance because they may be demonstrated mathematically. One medical speaker said that he did not mind a doctor looking at his watch repeatedly unless he held it to his ear to see if it was going.

Promptness means arranging the program on a time schedule and sticking to it, as was done at the last Annual Meeting of The Medical Society of New Jersey. We also recall a snappy meeting of the Monmouth County Medical Society in which the President called the meeting to order at the appointed hour, the Secretary read a brief summary of the minutes of the previous meeting, the chairmen of the important committees gave brief summaries of their activities, and new business was referred to the appropriate committees for study and hearings. The speakers of the evening were introduced at an early hour, and the discussions were brief and pointed. Everybody sat up and listened intently, and all had abundant time to enjoy simple refreshments and return home satisfied at the hour appointed

for adjournment. The secret of the promptness was the time schedule which the President had in mind although it did not appear on the printed program.

If the printed program carries a time schedule, the President will have no embarrassment in carrying it out, for that is what everybody expects him to do. Making the scheduled program is the responsibility of the program committee; the essential duty of the presiding officer is to watch his timepiece, and open and close every feature of the program on time.

Promptness is especially important to the visiting officers of the State Society whose presence at county society meetings is always desired and appreciated. Still more important is promptness to guest speakers, who must watch timetables in order to keep other appointed hours, and yet be at ease during the social hour with which every meeting should close.

Promptness is of such importance that its promotion may well be made a major project of the State Society.

A County Society Demonstration in Obesity Treatment

A fad of reducing body weight has spread over the country to such an extent that it has become of public health importance. Advertised means of removing surplus fat have found eager buyers, while their deplorable effects have been plainly evident to physicians. Since many people wrote to the press of New York City for information relative to weight reduction, one metropolitan newspaper turned to the Health Commissioner to furnish such information through the regular authoritative medical and public health channels. At this point the coordinating committee of the five County Medical Societies of Greater New York was approached by the Commissioner of Health. Representatives of the Board of Education and the newspaper were then invited to a conference. On September 6, 1933, the several groups agreed to cooperate in this public health experiment on obesity by first conducting classes for women only—the Board of Education to donate the gymnasiums and physical instructors; the newspaper to supply printed sheets of instructions and general maintenance diets; and the county medical societies to provide the medical supervision and stress the importance of the cooperation of family doctors.

The plan has been in successful operation during the winter and spring. Ten thousand women have enrolled in the classes. Every member of the class has been referred to her family doctor for a physical examination and diet; and a condition of her remaining in the class is that she continue to consult him and

to follow his advice. The family physician was given a newspaper clipping by the patient containing an 1800 calorie maintenance diet and a space on which he may record his own diet prescription to suit the individual need.

Each class has been in the immediate charge of a physician and a physical trainer. Lectures on exercises and diets have been given and the scientific principles of calories and diet lists explained. The newspaper has cooperated in an excellent way, printing information under the supervision of the Medical Societies, and supplying the diet forms.

The experiment has shown that the major factor in weight reducing is *diet*; but that the exercises with their sociability have been of great psychic value in holding the interest of those attending.

The experiment has also shown that medical societies will be recognized by lay groups when the medical leaders develop a practical line of approach in which essential duties are assigned to each group, lay and professional.

An important element in the success of the New York demonstration is the Secretary, who is a physician, experienced in public health and employed on full time by one of the component county societies. While volunteer work is essential in every county society enterprise, yet no man in active practice can give his full time to the details of a great activity involving contacts with several agencies. But cooperation can be secured if the project is centered in the proper man.

Public Relations

Problems of relations of the medical profession to lay health organizations exist in almost every community. The lay organizations make a distinction between the services of *health* and those of *sickness*. Their agents, largely public health nurses and welfare workers, are expected to give advice along hygienic lines only. They assume the ability to recognize *health*, but profess to leave the diagnosis of *sickness* to physicians. There are many cases on the border line between health and sickness in which public health nurses and welfare workers assume to make diagnoses, and even give treatments. Lay organizations sometimes support diagnostic clinics for the near-well groups, employing physicians who permit the nurses to give the necessary advice and treatment.

• Although these diagnostic clinics are fostered by lay organizations, they can be properly con-

ducted and supervised only by *organizations* of physicians whose representatives shall advise and direct the lay promoters. Fortunately, the members of the County Medical Societies have both the organization and the will to co-operate with the lay organizations; but a knowledge of the willingness of the physicians to give advice as to the need of the clinics and the method of conducting them does not seem to be general among the lay workers.

There is need that the County Medical Societies shall embrace every opportunity to make known their attitude, so that the laymen shall habitually seek the advice of the medical societies in all phases of their endeavors. This is largely a matter of popular publicity and education by the medical societies. This work could be a major project for the Woman's Auxiliary.

Proportion of Enrollment

New Jersey, which has 60 per cent of its physicians enrolled as active members of its State Medical Society, stands with the average of the states. The percentage of members varies from 50 in California to 70 in Kansas, according to the latest source of information, the 1934 edition of the Directory of the American Medical Association.

There is an unusual field in New Jersey for securing new members of the County Medical Societies, for the proportion of members to the number of practitioners has fallen—not because of a loss of members, but because the number of physicians practicing in the State has increased 13 per cent during the last three years. This is the largest increase of any State. Then comes New York with 8 per cent increase; Massachusetts, 6 per cent; and Pennsylvania, 4.6 per cent. The increase for the whole United States is 3 per cent. Seventeen states show a decrease in the number of their physicians.

The influx of new physicians has not been confined to any particular area; the increase in the larger cities is in about the same proportion as in rural areas. Every county has new practitioners ready to become members of its medical society on invitation of the Membership Committee.

The incentive to become members of the official organization of physicians is both personal and altruistic. Every man no matter how public spirited he may be, is worthy of his hire; and in serving his confreres and his fellow men, he promotes his own interests and satisfaction.

In promoting a more extensive distribution of medical service to those who are in need, the Medical Society of New Jersey has added many thousands of dollars to the incomes of private practitioners. If this leads non-members to join their county societies, it will also inspire them to practice their profession with greater efficiency and breadth of view.

Reducing C. W. A. Bills

The difficulties and inconsistencies of administering a new law are illustrated in the medical relief of the Civil Works Administration, to which attention is called by the letter printed on page 544. The same confusion appeared during the hurried preparation for the World War; but in those days saving expense and reducing bills were scarcely considered. Today medical relief is given promptly, and then comes a haggling over the pay which the doctors are to receive for their services.

The aggravating feature in the reduction of C. W. A. medical bills is that agreements between the Local Administrators and the Medical Societies are set aside, and twenty-five per cent cuts in the bills are ordered, although the committees of the medical societies have passed on them and in many instances have adjusted them to a prearranged standard of charging.

It is probable that the greater proportion of the disagreements are the result of "bureaucracy", or administration by means of a "chest of drawers", which is the common meaning of the word, bureau. The State and County E. R. A. officials are in personal touch with the medical committees of the State and the Counties, and are appreciative of the services of the doctors. But to the national administrators the county physicians and officials are names on bureau files of impersonal reports of cases of relief; and the agreements between the two local groups are made subservient to arbitrary budgets of a distant government.

Disagreements over C. W. A. bills would be far less common if the physicians of all the States had an E. R. A. organization as active and efficient as that of New Jersey and its counties.

Popular Medical Publicity

The people generally are not aware of the civic service rendered by the county medical societies; or of the practical nature of their activities. They do not realize that the Societies, through their officers, are ready to advise the people collectively on any subject relating to public health. They suppose that the private opinion of any physician is that held by the majority of his colleagues. They promote a clinic in charge of an individualistic doctor who holds opinions opposite to those of his medical brethren. They maintain this attitude because the physicians themselves do not teach the people otherwise.

Silence either "lends consent", or indicates indifference. The ethical silence imposed on the medical profession is a development of the rule against boastfulness and self-advertising by individual doctors; it was not intended to bar medical societies from educating the people in subjects relating to public health.

Medical publicity and education is not needed so much in subjects of scientific medicine as in the topic of medical organization. It is not

proposed to conduct a health column on "How to Keep Well" or "What to Do in Emergencies". The most important subject in medical publicity is that relating to the County Medical Society and its place in the community along with the church and the school. The medical advice which people most need may be summed up in the following sentence:

Go to your doctor for personal advice; and to your County Medical Society in all problems of community health.

The Woman's Auxiliary to The Medical Society of New Jersey stands ready to offer its services in popular medical publicity. It proposes to make the local arrangements for the delivery of lectures by physicians appointed by the County Medical Society. The Auxiliary would be the publicity agent of the medical society, and would act strictly under its direction.

The active aid of the Auxiliary will supply the element that has hitherto been lacking in plans for the essential project of popular medical education. (See page 551.)

ORIGINAL ARTICLES

INTRATHORACIC ANATOMY FROM THE ROENTGENOLOGIST'S STANDPOINT

By WILLIAM WALLACE MAVER, M.D., Jersey City, N. J.

Read before the Radiological Section of the Medical Society of New Jersey at the Annual Meeting in Atlantic City, June 6, 1934.

In presenting the subject of Intrathoracic Anatomy before a group of roentgenologists, I realize that much of the subject matter will bear a relationship to the proverbial coals to Newcastle, but because of the fact that an intimate knowledge of anatomy plays such an important part in the everyday practice of the roentgenologist, I hope that a reiteration of such a subject will not prove unprofitable.

The Thoracic Cage. The thoracic cage varies in size, shape and symmetry in practically every individual and conforms very definitely to the habitus of the subject. Considering the arrangement and number of the ribs, it is rather surprising that we do not encounter malformations or anomalies in development more often than we do. When they are present, they may or may not be of any clinical significance except to explain thoracic asymmetries—or to produce confusing physical signs. For instance, fused ribs have given the impression of areas of dullness suggesting pathology, and when present, they should always be described by the examiner.

The conformation of the dorsal spine to form the posterior thoracic wall should be observed, and any abnormality of structure, symmetry or development given adequate consideration.

Complete visualization of the segments of the sternum is seldom satisfactorily accomplished, as it is hidden in the direct sagittal plane by the dense image of the cardio-vascular structures and dorsal spine, and in the right and left oblique projections it is distorted in size and contour. It is usually best seen in the erect posture, in examinations that are being made for mediastinal or heart lesions; its chance visualization is frequently the most satisfactory. In children, the ossification centers of the sternum may, under certain conditions, produce confusion with hilus shadows

because of their resemblance to enlarged bronchial glands.

It seems practical to regard the thoracic cage as a structure that is divisible into main divisions and subdivisions. These occupy definite locations or planes in the thorax, and a knowledge of the structures that enter into each space or subdivision enables one to recognize the part involved in a pathological process.

It is therefore suggested that the thoracic cage be first regarded as being composed of three major spaces—the mid space for the mediastinal structures, the right and left space for the respective pleural sacs and lungs.

In order to appreciate the size of the middle division, a cross-section of the chest in its mid-portion reveals that it occupies an area slightly less than that occupied by the left lung. The greater part of this space is occupied by the heart and pericardium, and is usually not thought of as mediastinum by the roentgenologist, who is interested primarily in the superior and posterior mediastinal spaces which stand out as areas of lesser density anterior to the dorsal spine.

The ratio of these three major spaces is approximately 9 for the right pleural sac, 8 for the left pleural sac, and 6 for the space known as the mediastinum.

The Diaphragm. The diaphragm is a structure that stands out in bold relief on the roentgenogram, producing two dense dome-shaped shadows with the convexity directed upward toward the thoracic cavity. The excursion of this structure to perform its respiratory function is one of the points of roentgenographic observation, and a limitation in its degree of excursion may be a signal of intra-thoracic or sub-phrenic pathology. The height of the domes and the depth of its sulci are usually carefully noted in the sagittal study. It is considered of equal importance to study the con-

formation of the domes and the depth of the sulci in the lateral plane, as it is only in the latter projection that the depth of the posterior sulci can be appreciated. Fluid in this portion of the pleural sac may pass completely unobserved if observations are confined to the sagittal plane only.

The diaphragm is a muscular and membranous partition originating from the sternum, ribs and lumbar spine, and is inserted in a central tendon. Its posterior attachment to the lumbar spine by the right and left crura, and the external, mid and internal arcuate ligaments serve to reinforce the diaphragm at the sites of opening.

The crura are two fibro-muscular bundles that pass upward in front of the aorta where they cross and then re-cross forming an elliptical opening which encircles the esophagus slightly to the left of the mid-line. Another major opening in the diaphragm lies in the central tendon to the right of the mid-line for the passage of the vena cava.

The finger-crossing arrangement of the crura is a rather complicated arrangement of muscle structure and is important to remember in cases of cardio-spasm and diaphragmatic herniation. It is believed that abnormal arrangements of the muscle fibres at this decussation result in some degree of stenosis, and this, either with or without alteration in sympathetic nerve control, probably contributes to cardiospasm. On the other hand, an abnormal degree of relaxation of the crura predisposes to herniation, recognized by a persistent gas shadow above the diaphragmatic level.

From the evidence at hand to date, it would therefore appear that congenital malformations at this opening play a major rôle in lesions of this type that develop or are discovered later in life.

Occasionally, the diaphragm is deficient, producing hernia into the pericardial cavity through the central tendon, or into the thoracic cavity through the lateral portions of the muscle, either due to absence or weakness of the lateral muscle.

The Mediastinum. To the roentgenologist, the mediastinum is an important area of ob-

servation because of the frequency with which this region is invaded by pathological processes in either the structures bounding it or within its confines. Needless to say, a survey of the chest is not complete unless this space is carefully examined.

The mediastinal space has been arbitrarily divided into four portions—the superior, middle, anterior and posterior—according to the relation which they present to the pericardium.

The *superior* mediastinum is that part of the general space which lies above the level of the pericardium. It is bounded in front by the upper segment of the sternum, posterior by the four upper dorsal vertebrae, and laterally by the mediastinal pleura. From the roentgenologist's viewpoint, the important structures within the superior mediastinal space are the aortic arch and the vessels which spring from it, the trachea, the esophagus and the thymus gland.

The *middle* mediastinal space is the wide part of the space lying below the superior mediastinum, and containing the pericardium.

The *anterior* space lies between the pericardium behind, the sternum in front. Above the level of the fourth costal cartilage, a space hardly exists, but below this level, the left pleura falls short of the right pleura, and a space is formed which contains a few lymphatic vessels and small arterial branches.

The *posterior* mediastinal space may be regarded as a continuation of the superior space. Its upper limit is the fourth dorsal vertebra. In front it is bounded by the pericardium, behind by the eight lower dorsal vertebrae, and on each side by mediastinal pleura. It contains the descending thoracic aorta, the thoracic duct, the esophagus and the vagus nerves.

The superior and posterior spaces are of more interest to the roentgenologist than the anterior and middle spaces. The combination of the superior and posterior spaces are what the roentgenologist sees and describes. It is probably best examined in the right and left oblique and lateral planes, and one orients himself by the sharply defined posterior heart wall forming its anterior limit and the dorsal bodies its posterior wall.

Encroachment upon this space by diseases

of its enclosed structures results in a distortion or diminution of its size and an alteration in its contour.

The elasticity of the pleural partitions that form the lateral boundaries of the mediastinum allows a displacement of the mediastinal structures to the right or left of the mid-line when an increase or a decrease in pressure occurs in the right or left hemithorax. Once the negative or positive pressure is increased or diminished, the inherent elasticity of the mediastinal walls brings the mediastinal structures back to a more normal position.

This is observed most frequently in pleural effusions or pulmonary atelectasis—and in the case of pleural effusions explains what is almost paradoxical—namely, the persistence of a fluid level at the same height, even though several hundred centimeters have been withdrawn between examinations.

The elastic recovery property of the partitions diminishes in long-continued dislocations of the mediastinal structures. Witness the relatively quick snap back of the mediastinum in spontaneous pneumothorax and pulmonary atelectasis of short duration, as compared with the sluggish return of the mediastinum in untreated empyemas and chronic bronchial obstructions.

The Esophagus. The esophagus begins at the termination of the laryngeal pharynx at the level of the sixth cervical vertebra and ends two inches below the diaphragm at the cardia. It occupies a position in front of the vertebral column and lies in the superior and posterior mediastinum. In the neck, the esophagus is between the vertebral column and the trachea. In the thorax, it lies in close proximity to the trachea, the left main bronchus and the pericardium. Viewed sagittally, it occupies an almost vertical axis, and viewed laterally it follows the curves of the cervical and dorsal spines to about 5 cm. above the level of the diaphragms where it inclines forward and to the left, to join the stomach.

The aortic arch is normally anterior to, and at the left side of the esophagus, and its close proximity to the esophagus produces a normal imprint upon the filled esophagus. Occasionally, an anomaly is present and the aorta

passes posterior to, and on the right side of the esophagus. Under these conditions, the esophagus at this level is projected forward, which results in difficult swallowing. The calibre of the tube varies and is irregular, and the various points of anatomical narrowing are (1) introitus, (2) the level of the aortic arch, (3) crossing of the left bronchus, (4) level of passage through the diaphragm and (5) termination at cardia.

Some believe that the esophagus is a closed tube with its mucosa in apposition when at rest. Others believe that only the cervical and upper dorsal esophagus is closed, and the mid and lower esophagus show gapping of its lumen. The tube is narrowest at the cardia in which location its lumen becomes conical with the base directed upward. Barium in this portion of the esophagus casts an image simulating, at times, an inverted collar-button, its normal appearance, which should not be confused with herniation.

An article by H. E. Wright and E. B. Freeman in *RADIOLOGY* (Feb. 1934) describes the observations of these men upon the descent of a meal through the esophagus during various phases of respiration. During numerous esophagoscopic studies, E. B. Freeman noted that the lower end of the esophagus was seen to open and close rhythmically, synchronous with respiratory action. They have observed the barium mixture pass through the esophagus first at the end of a full forced inspiration, second during a suspended respiration in the midst of inspiration or expiration, and third at the end of a full expiration—and have noted the following:

"1. Barium swallowed at the end of a full forced inspiration passes at a leisurely rate through the cardia into the stomach.

"2. Barium swallowed when respiration is suspended in the midst of a normal inspiration or expiration passes very rapidly through the esophagus and cardia in a thin stream, the organ itself being in a more or less collapsed condition.

"3. Barium swallowed when respiration is momentarily suspended at the end of a forced expiration is held in the esophagus for several seconds and causes a rather remarkable dila-

tation of the organ, which, in some cases, is almost as marked as is seen in early cardiospasm."

These men further observe that "habitus appears to play a part in esophageal delay at the cardia. The long-chested individual shows slight delay, and therefore, the esophagus is more readily visualized. The short-chested individual, on the other hand, shows very rapid passage, and is therefore more difficult to visualize. Occasionally, cases are noted with delay on suspended inspiration, suggesting some mechanical factor. These subjects may be cases of potential cardiospasm."

The Lungs and Pleura. In childhood, the trachea lies to the right of the mid-line until about the sixth year of life when it assumes the mid-line position to which it adheres except in its lower portion where it deviates slightly to the right. It is widest in its mid-portion and shows slight narrowing in its upper third at the level of the thyroid.

The left bronchus is about twice as long as the right, being measured from the bifurcation to the location of the first collateral branch. The right bronchus has a greater cross-diameter than the left in the ratio of about 100:78. The larger size of the right bronchus is consistently explained by the fact that the right lung is larger than the left. The right bronchus takes a more vertical course than the left, and its angle is about 24 degrees. It is therefore more in the line of the trachea, and this, as well as its greater width, is responsible for the tendency of foreign bodies to drop into the right in preference to the left bronchus. The more horizontal course of the left bronchus is probably caused by the marked projection of the heart to the left side of the mid-line, the angle of the left bronchus being about 45 degrees. In the interspace between the bronchi, is a cluster of bronchial glands, and an irregular chain of glands extends along each bronchus toward the hilum of the lungs.

Most interesting is the relationship of each pulmonary artery to each bronchus. The pulmonary artery crosses in front above the level of the first collateral branch, and then turns around its outer side to gain its posterior as-

pect. All the left bronchial branches are therefore hyp-arterial. The right pulmonary artery crosses in front of the continuation of the right bronchus below its first collateral branch. This branch is therefore termed eparterial, and probably explains the semi-circular area that occasionally stands out in the hilus regions simulating an enlarged gland, cyst or perhaps a cavity, but is a normal anatomical landmark.

The lungs are normally free in the chest cavity except at the roots, and being free, they are compressible and displaceable in all portions except at their root attachments. This free mobility of the lungs increases from the mid-line toward the parenchyma and explains the S-shaped curve of Ellis noted in uncomplicated pleural effusions, the curve level being low at the mid-line and increasing in height toward the axillary line. The fluid in the pleural sac presses the lung upward, and the lung at the periphery being more mobile than the lung close to the root, gives more to this fluid pressure, and the fluid assumes a curved line. To a lesser degree but for the same reason, mediastinal effusions show a curved character of fluid line, from the root level upward and outward, or from the root level downward and outward, the apical and basal portions of the lung compressing and the root portion remaining fixed.

The lung fields have been divided by Dunham into three parts.

1. Inner or central zone, containing hilus structures.
2. Middle zone, containing larger bronchial subdivisions.
3. Outer zone, containing finer bronchioles and alveoli.

Hilus markings are produced by the pulmonary arteries and vein, bronchial artery, lymphatic vessels and lymph glands, and connective tissue surrounding all of them. Peribronchial markings are produced by bronchi and their smaller subdivisions and their surrounding structures, blood vessels, lymphatics and connective tissue. Since the structures that produce them are peribronchial in nature, they have been so named. Any accentuation so that heavier markings encroach upon the outer zone, is evidence of pathology. Tumor forma-

tion may exist without accentuation of peribronchial markings, which is practically the only pulmonary lesion that does not, as a rule, accentuate them.

A fairly intimate knowledge of the boundaries of the various pulmonary lobes is of value to the roentgenologist. If, in the lateral film of the chest, a line is drawn beginning from about the fourth rib at its spinal attachment, obliquely downward and forward to the mid-portion of the sixth costal cartilage, we have a plane of the major interlobar septum that divides the upper from the lower lobe. If in the right lung another line is drawn from the above line at the fifth rib in the mid-axillary line, horizontally forward, we thereby obtain the upper boundary of the middle lobe.

These major divisions are readily remembered and are of value in determining the location of areas of pulmonary or pleural pathology, these lesions being more readily localized in the lateral than in the sagittal projection.

The lines of pleural reflection are also important. The posterior line of diaphragmatic pleural reflection is obtained by drawing a horizontal line through the inferior edge of the spinous process of the first lumbar segment. Where this line intersects the mid-lateral line, is the level of posterior pleural reflection.

The anterior line is on the level of the spinous process of the twelfth dorsal vertebra and the intersection of the inter-mammillary line.

The pleura is plentifully supplied with lymphatics which communicate with the cavity by means of minute orifices or stomata which carry away excess fluid. Over the ribs and in the mediastinal pleura, they are absent.

Roentgenographic Landmarks. The fourth dorsal segment is an important anatomical landmark from the roentgenologist's standpoint. At this level is the imaginary plane dividing the superior mediastinum from those below. The division of the trachea is at this level, as are the upper limits of the aortic arch. A familiarity with the structures located at this level normally, enables one to decide whether other images noted represent abnormal findings. The pleural interlobar septum

is just below this level and passes obliquely downward and forward to the sixth rib level in front.

The structures above the plane of the fourth dorsal segment are the superior mediastinum containing the aortic arch and the vessels which spring from it, the trachea, esophagus and the thymus gland. Into this space encroaches the dilated aorta, the intra-thoracic thyroid, the pathological thymus, tracheal and esophageal diverticula, and mediastinal effusions secondary to cervical infections, etc.

The main stem bronchi are in a plane below this level, but the communicating branches and a part of the upper lobes of the lungs lie above this plane.

In the apices, a dense horizontal or curved shadow is frequently noted that is produced by the slightly ptotic condition of the apices. This ptosis is normal and is usually slightly more pronounced in the right lung. This curved shadow may be noted only in the right apex, and when seen is believed to be due to soft tissue structures and blood vessels passing across the apical thorax. It is worthy of note because of its resemblance to apical pleural thickening. Crane's inverted comma in the right apex indicates an azygos lobe produced by the vena azygos major as it creases the upper lobe.

Circular or semi-circular hilus shadows in close proximity to the roots have erroneously been considered as cavities. These represent the site of arching over and under of the vena azygos major on the right side and the pulmonary artery on the left side in their relationship to the right and left main bronchi. Oval or well-rounded areas of increased density are normally due to blood vessels projected on end or in an oblique axis by the x-ray beam. Irregular areas of increased density usually represent calcium deposits and are a pathological entity. Pectoral muscles and breast shadows in the mid and lower thoracic regions, and nipple shadows, should not produce confusion.

The cardiac silhouette and the pulmonary segments have not been considered in this discussion, because each is worthy of a more detailed description than is possible in a general survey such as this.

THE PROBLEM OF SILICOSIS, A PRACTICAL VIEWPOINT

By RAPHAEL POMERANZ, M.D., Newark, N. J.

Read before the Section on Radiology at the Annual Meeting of the Medical Society of New Jersey, in Atlantic City, June 7, 1934.

SUMMARY

1. A practical plan is suggested for a "New Deal" in the silica industry.
2. Critical evaluation of the means of diagnosis and the importance of the correlation of all the given data are emphasized.
3. Included in this paper is a report of findings of serial radiographic follow-up of twelve men exposed for short periods to the fine quartz dust of the pulverizing plants of New Jersey.
4. The necessity of testing the functional disability of the living silicotic individual by clinical methods is stressed.
5. Suggestions for the set-up of a Special Compensation Board and for compensation schedules are made.

During the last few years the problem of silicosis has attracted wide public attention. Through the work of many serious investigators who were able to prove the dangers and hazards of the disease, it has increasingly aroused the medical conscience. This interest in the subject was further accentuated by modern improvements in industrial production methods, resulting in the manufacture of a very fine Silica powder, now an important constituent of many chemical compounds in daily use. Although scientific data have been gathered no practical plan for giving the industry a "New Deal" has been formulated. The "New Deal" for this industry means the highest degree of protection available to the employer and worker consistent with our present knowledge.

We know that silica in form of SiO_2 is very injurious to the human lungs when it is inhaled in excessive amount. Apparently the silicates are also harmful. The extent of the damage to the lung tissue will have to be determined by further experimental work. I wish to bring to your attention at this point a recent article published by W. R. Jones in the Bulletin of the Institution of Mining and Metallurgy in London. In this paper, Jones attempts to prove that the chief noxious agent to the lungs of the workingmen is sericite, a hydrous aluminum silicate, commonly found in the rocks or the mines where silicosis is prevalent. He states that sericite occurs in small acicular fibers, from about a half to two microns in

size, which remain in the dusty atmosphere of the mines many hours after blasting. Jones believes that the same particles are found in the lungs at autopsy. He demonstrates this by examination of the mineral residue extracted from the lungs of the deceased by means of a petrologic microscope. In his opinion, therefore, particles of quartz, though less than ten microns in size, do not cause the damaging fibrosis, because they enter the alveoli in insufficient amount; sericite fibers, on the other hand, are less than two microns in size and, therefore, enter the alveoli more readily. We also know that as a result, a chemical and possibly colloidal affinity between SiO_2 and lung tissue exists, the former producing a deleterious interstitial fibrosis, which diminishes the vital lung capacity. One reads that the harmful particles are those less than ten micra or even five micra in size. In my own experience with a large series of acute cases of silicosis, silica particles of one micron or less have been found in the lungs of the deceased. It is, therefore, my belief that these small particles, one micron or less, are the most dangerous. The microscopic examination of the manufacturing product in our series shows pure quartz particles, SiO_2 , most of which are smaller than one micron: no sericite was found. Further examination by means of a petrologic microscope disclosed no evidence of sericite in the mineral residue of the silicotic lungs of the deceased. Our task is to prevent the entrance of these fine particles into the

lungs of the workingmen. This was attempted by mechanical measures, masks, ventilation, proper construction of the machinery. But in spite of all these modern mechanical improvements, silicosis is just as widespread as before; this means that mechanical protection is still insufficient.

Mr. J. Bloomfield, sanitary engineer of the United States Public Health, has suggested in a personal communication that the introduction of the modern mechanical improvements in different plants is too recent to permit any conclusion as to their efficiency.

My answer to this is that, even the South African Rand Mines, where modern mechanical improvements have been used for the longest time, are unable to report a significant decrease in the incidence of silicosis.

The diagnosis of silicosis is based on: 1, history; 2, clinical findings; 3, x-ray findings. The weakest link in this chain is the clinical examination; the strongest is the x-ray evidence. The diagnosis, however, is incomplete unless the data gained from the three sources are correlated. It is generally accepted that the most important evidence in cases of established silicosis is the x-ray findings. In such cases the roentgenogram shows us: enlarged dense hilar shadow, haze over central lungfields, increased fibrous network, nodules, mottling, etc.—all indicating glandular and interstitial fibrosis. In other words, it gives us a relative picture of the not aerated-fibrosed lung tissue to the aerated lung tissue. It does not, however, give us any information about the relative amount of the residual function in the remaining healthy lung tissue. We may gain some insight into this by fluoroscopic examination of the respiratory excursions of the diaphragm; but this is far from accurate. Our judgment must then depend on our experience with similar cases; but this is not objective. The inadequacy of the roentgenogram informing us as to the function of the silicotic lung is even more noticeable in earlier cases of silicosis where the x-ray symptoms are not as clear and pronounced. For the sake of compensation, the most important issue is the remaining function of the lung. We must, therefore, determine more thoroughly and accurately the remaining function of the sili-

cotic lung by other clinical methods. To do this we must measure chest expansion, test vital lung capacity by proper instruments, test the function of the heart, simulate examination of the heart while one determines the capacity of the individual in holding his breath, etc. We then study the history, type of exposure, amount and size of the silica particles and its chemical composition. Obviously, only a correlation of all these data can give, even to the experienced investigator, a clear picture of exposure and extent of involvement.

The present report covers a four-year serial radiographic "follow-up" of twelve cases of acute silicosis in the early stages from a pulverizing plant in New Jersey. Of these, four are white men, the others colored. One white man and four colored men were exposed for a period of two to six months inclusive. All of these men were rayed late in 1930 or early in 1931, and again in March, 1934. The same technic and tube were used in making the comparative films as in the original examinations. The recent films do not show any progress or accentuation in the x-ray findings. This proves conclusively that the exposure was slight and caused no organic damage. Of the other seven cases, three were white men and four colored.

1. C. W., colored, 39 years old, three months' exposure. X-rayed 6-19-30, and 3-7-34. Worked in the bagging room. A suggested hilar fibrosis has advanced to a definite hilar fibrosis. Diaphragmatic expansion is $\frac{1}{2}$ to $1\frac{1}{2}$ inches. (Moderate restriction.)

2. C. H., colored, 40 years old, six months' exposure. X-rayed 7-22-30 and 3-7-34. Early hilar and middle lung fibrosis, advanced to a definite interstitial fibrosis, involving also the central lungfields. Expansion of diaphragms $\frac{1}{2}$ to 1 inch. (Markedly restricted.)

3. J. C., colored, age unknown, eight months' exposure. X-rayed 4-28-30 and 3-6-34. Hilar and interstitial fibrosis of central lungfields has advanced to a general interstitial fibrosis involving practically the entire lungs, particularly pronounced in both subclavicular regions, suggestive of reactivation of a latent tuberculosis. Diaphragmatic expansion $\frac{1}{2}$ to 2 inches.

4. E. C., colored, age 25, eighteen months' exposure. X-rayed 2-6-31 and 3-5-34. Diffuse interstitial fibrosis of the central lungfields has markedly progressed in both upper lobes causing large tumor-like masses in the subclavicular regions with upward displacement of the base of the heart. Diaphragmatic expansion 1 to 2 inches.

5. M. C., white, 30 years old, eighteen months'

exposure. X-rayed 7-28-30, 8-21-31 and 4-7-34. Findings of early tuberculosis and silicosis, particularly in the left upper lobe, has progressed to active tuberculosis with pleural effusion in the left half of the chest, which healed in 1934 with a marked shrinkage and pleural thickening of the left side. The left diaphragm is completely obscured and fixed. The right diaphragm expands from ½ to 1½ inches and shows old adhesions.

6. H. F., white, 57 years old, two years' intermittent exposure. X-rayed 10-1-30, 4-20-31 and 3-7-34. A moderate hilar fibrosis has advanced after a period of 3½ years to a marked hilar and interstitial fibrosis with tumor-like infiltration in both subclavicular regions, more on the right side causing shrinkage and strongly indicative of re-activated T.B. Diaphragmatic expansion ½ to 2 inches.

7. C. R., white, 25 years old, three years' intermittent exposure. X-rayed 9-24-30, 4-29-31 and 3-7-34. A moderate hilar and middle lung interstitial fibrosis slightly advanced in amount. Diaphragmatic expansion 1 to 2 inches.

COMMENT

This brief outline of Roentgen findings demonstrates definitely the progressive fibrosis in those subjects who inhaled a sufficient amount of silica particles. It also demonstrates the development of tuberculosis, apparently reactivated, in some of these patients after the exposure to silica dust. The amount of fibrosis is evidently not dependent upon the time the workingmen were employed, because it is apparent that some of the men in this series inhaled more dust particles than others. The definite proof of a sufficient exposure to silica is the evidence of advancing pulmonary fibrosis three years after cessation of the employment. It appears to me that the best method for checking the doubtful cases of occupational exposure to silica is the use of repeated serial radiographic examinations (once a year) for a three-year period. If the x-ray fails to disclose any increase in fibrosis, the patient should be classified as negative.

After this brief critical evaluation of the diagnosis of silicosis, let us consider the methods of prevention. Since mechanical protection is still insufficient, other prophylactic measures should be taken. Among these are: 1. Pre-employment examination of every applicant for a position. This should include a fluoroscopic and radiographic examination of the chest. No one with signs of latent or active tuberculosis, other respiratory infection, early

silicosis from previous exposure, or chronic cardiac disease should be accepted. Those employed should have a periodic examination including x-ray every three months. They should be informed of the dangers of their work, and should receive instructions in the use of the masks or other methods of mechanical protection. These should be repeated and checked once a week. 2. Reducing the hours of labor for the individual worker according to the severity of the exposure. Change his type of work frequently in the same plant, from the more hazardous to the less dangerous ones. 3. If at this periodic examination signs of pulmonary involvement—tuberculosis or silicosis—should be disclosed, the worker should be advised to change his occupation and be compensated according to his disability.

Since, in spite of all these measures, silicosis will still occur, compensation is absolutely necessary. All countries in which the industry is extensive have some compensation law covering this disease. It would be only fair to the worker, and it would protect the employer from abuses, if we were to add silicosis to the list of compensable diseases.

The Compensation Board should be so organized that in every large manufacturing district where exposure to silica is prevalent, a special board is formed consisting of four to five men experienced and familiar with manifestations of the disease. The board should, therefore, consist of a clinician, a radiologist, a pathologist, a physician versed in compensation work and an engineer familiar with the types of exposure.* This board could be reduced to three members if the clinician has experience in silicosis and in compensation work, and if the radiologist had studied silicosis histologically or vice versa.

I should suggest compensation schedules as follows:

Third stage of silicosis or silico-T.B.—
or T.B. silicosis

Second stage of silicosis with or without T.B.

First to 2nd stage with or without T.B.

First stage

100%

50% to 75%

25% to 50%

25%

Doubtful cases should be eliminated by the

* Suggested by J. Bloomfield.

above suggested serial radiographic examinations for a period of two to three years. The lungs should be rayed once a year. If after two to three x-ray examinations no signs of the disease are found, the patient should be discharged as negative.

The percentages are based on 100 per cent total disability as defined in the State of New Jersey. The stages are based on the old conventional type of classification, but with this difference: that the greatest attention is paid to the established functional disability of the lung in a silicotic worker. I believe that the old classification is simpler and therefore preferable for compensation work.

There still remains a great difficulty with

those cases which are doubtful or where the exposure to silica or silicates must be questioned. I feel that in these cases the Board should try to reach the truth by examination of the employment records, which include the type of exposure, etc. When it is definitely proved that the data given by the worker and his attorney are erroneous, the State should prosecute both. Only by such measures can we expect to eliminate these suits of doubtful exposure. Since we know that silicosis is a progressive and irreparable disease even after cessation of exposure, one should be allowed to reopen a case if, after compensation has been allowed, the condition of the worker has become progressively worse.

THE CLASSIFICATION OF ANEMIA

By RUSSELL L. HADEN, M.D., Cleveland Clinic, Cleveland, Ohio

Read before the Pediatric Section of the Medical Society of New Jersey at the Annual Meeting in Atlantic City, June 6, 1934

SUMMARY

A laboratory and clinical classification of anemia has been outlined.

The results of the blood study have been correlated with the clinical classification.

The importance of the clinical and hematologic classification in relation to the treatment of anemia has been emphasized and the lines of treatment indicated.

Changes in the erythrocytes must always occur in anemia since the hemoglobin is constantly decreased. Erythrocytes may be decreased in number, the size may be altered, or the hemoglobin content per cell may vary from normal. No patient with anemia should be treated without a complete laboratory and clinical examination. The blood must be properly studied and classified in the laboratory; the patient must have a careful clinical examination; the results of the laboratory and clinical studies must be correlated. It is my purpose in this paper to describe a method of study of anemia which has proved most valuable in our hands.

No clinical or laboratory classification of anemia suggested in the past has proved satisfactory. Most clinicians have employed only

a rough grouping into primary and secondary types. In the primary group have been placed the anemias without apparent cause and those with a color index over 1.00; in the secondary group, those with known cause, and those with a color index less than 1.00. Such a classification confuses clinical and hematological data and is not really workable.

In every animal the blood is undergoing constantly a rapid ebb and flow. Erythrocytes and hemoglobin are always being formed and destroyed. The life span of the erythrocyte of man is about four weeks, which means that every month the entire store of circulating and reserved red cells is replaced. An anemia is simply a loss of balance between this normal process of destruction and replacement. In every anemia it is necessary to know:

1. How many cells and how much hemoglobin have been lost.

2. What qualitative changes, such as variation in size and hemoglobin content of the cells, have taken place.

3. How rapidly the cells are being destroyed.

4. How rapidly the cells and hemoglobin are being replaced.

This information can be easily obtained by a systematic blood study. A red cell count is done, the hemoglobin is determined in grams per hundred cubic centimeters, and the volume of packed cells per hundred cubic centimeters of blood is measured by centrifugalization of 10 c.c. of blood containing an isotonic anticoagulant. From these data the volume and hemoglobin content of the mean cell can be calculated and also the amount of hemoglobin per unit volume of cell relative to normal. The best index of the rapidity of the blood destruction other than the red cell count is the amount of bile pigment in the blood, provided there is no obstruction of the biliary tract. The activity of red cell formation in the marrow is best determined from the level of reticulocytes in the circulation since these are young cells. (For the technical details of such a blood examination, see the author's paper "The Technique of a Blood Examination", Jour. Lab. & Clin. Med., 17: 843-859, 1932.)

The primary classification of anemia from a laboratory standpoint is based on the volume and hemoglobin content of the mean red cell. Only six groupings are possible.

1. *Normocytic and normochromic*. Here the volume and color indices are within normal limits (0.90 to 1.10). It is apparent that the number of cells must be reduced if anemia is present.

2. *Macrocytic and hyperchromic*. In this type the mean cell is larger and contains more hemoglobin than normal so both the volume and color indices are greater than 1.00. Since the amount of hemoglobin per cell is increased, the number of cells is always decreased.

3. *Macrocytic and normochromic*. The cells are large but the mean amount of hemoglobin per cell is normal; the volume index is greater

than 1.00; the color index is within normal limits.

4. *Macrocytic and hypochromic*. Here the volume index is still increased, but the color index is below normal.

5. *Normocytic and hypochromic*. The mean cell volume and the volume index are within normal limits but the hemoglobin per cell is decreased as shown by a color index of less than 1.00.

6. *Microcytic and hypochromic*. The volume index is below the lower limit of normal (0.90). The hemoglobin per cell in such a case is necessarily less than normal so the color index is low. Usually the number of red cells shows little if any decrease.

To complete the laboratory study the pigments in the plasma are measured by comparison with a dilute solution of potassium bichromate and recorded as the icterus index or determined quantitatively by the van den Bergh method. A vital stain is made and the reticulocytes counted; a film stained by Wright's stain is examined for variations in diameter and shape, basophilia, nucleated erythrocytes, relative number of platelets and a differential count of the leucocytes.

The laboratory classification of anemia is thus simply a descriptive one. An etiologic classification is always the most desirable one, and such a classification may be made from the clinical standpoint. A satisfactory clinical grouping based on method of production is shown in Table I.

TABLE I.
CLINICAL CLASSIFICATION OF ANEMIA BASED ON METHOD
OF PRODUCTION

- I. Increased Blood Loss
 - a. Mechanical from acute hemorrhage as in:
 1. Trauma
 2. Peptic ulcer
 3. Uterine bleeding
 4. Disturbance in blood coagulation
 - b. Accelerated destruction as in:
 1. Chronic hemolytic icterus
 2. Hemolytic anemia due to infections and poisons
- II. Decreased Blood Formation
 - a. Depression of marrow function in:
 1. Idiopathic aplastic anemia
 2. Cachexia, chronic intoxication, metabolic disturbances, poisons, radioactive substances, malignancy or infiltration of marrow by tumor or leukemia.

- b. Deficiency in specific substances necessary for normal red cell formation as:
1. Deficiency in specific anti-anemic factor of liver leading to pernicious and other macrocytic anemias.
 2. Deficiency in iron and perhaps other unknown substances necessary for hemoglobin formation as in chronic hemorrhage, dietary deficiency in iron, and disturbance in absorption or assimilation of iron (idiopathic, hypochromic and microcytic anemia).

The laboratory and clinical findings may be correlated and in some instances the laboratory findings indicate the etiology of an anemia from a clinical standpoint. If the anemia is caused by an acute mechanical loss of blood, the cells remaining are normal in size and hemoglobin content, and the volume and color indices are normal. The anemia is normocytic and normochromic. The bile pigments in the plasma are decreased and the reticulocytes are increased if the bone marrow responds normally. With increased hemolysis the bile pigments are markedly increased, so the icterus index is high. The reticulocytes are usually much increased in a chronic hemolytic anemia since the bone marrow is overactive in an attempt to compensate for the increased blood loss. The volume and hemoglobin content of the mean cell show little change.

In the large group of anemias due to a simple quantitative defect in delivery of the red cells from the marrow, such cells as are formed are normal in size and hemoglobin content. The volume and color indices are normal. Not infrequently, however, the anemia resulting from malignancy, toxemia, infection, and other causes is not simply a quantitative deficiency, but is qualitative also, since the primary disease interferes with the absorption or utilization of the substances necessary for the normal formation of blood. Here the blood findings are a combination of those characteristic of a quantitative and a qualitative deficiency.

The qualitative deficiencies show characteristic findings. With a deficiency in the specific anti-anemic factor of liver, the red cells in the circulating blood are larger than normal, so the volume index is increased. This specific principle is necessary for the normal growth

from the megaloblast stage. Megaloblasts are large cells; hence the macrocytosis since maturation is not normal. The bone marrow is red because it is overactive. Many cells die in the marrow because of their inability to mature and thus increase the bile pigments in the plasma. The reticulocyte count is low. With a deficiency in iron, the cells are small and deficient in hemoglobin although the total red cell count is decreased little if at all. Hypochromia as evidenced by a low color index is the first abnormality to develop if the supply of iron is inadequate. If the hypochromia continues, the cells decrease in size and the volume index falls, probably because there is no need for a normal cell mass, since there is no hemoglobin to fill it. The formation of bile pigment is at a low level because less hemoglobin is destroyed and hence the icterus index is decreased. The reticulocyte count is variable but never high.

Not infrequently more than one factor is operative in the causation of an anemia, and so the laboratory findings represent a summation of those characteristics for the different types of anemia. If there is a deficiency in both iron and the anti-anemic factor of liver, the macrocytosis and hyperchromia due to the lack of the anti-anemic factor of liver may be neutralized by the microcytosis and hypochromia of the iron deficiency. The cell size and hemoglobin content may then be within normal limits. Malignant disease may depress the marrow, interfere with the utilization of a specific factor, and also cause hemorrhage. In such a case, there are three factors in the causation of the anemia.

DISCUSSION

With the laboratory and clinical study here outlined a satisfactory classification of almost every anemia can be made, and the proper treatment administered. The classification is more difficult in cases in which more than one factor is operative. It is increasingly evident in the study of anemia that the utilization of a specific factor may be interfered with even when the supply is adequate. Infection often prevents the normal utilization of specific factors. Thus it is well recognized that if an

infection develops in a patient with pernicious anemia, the intake of liver or liver substitute must be increased. This fact indicates that the infection interferes with the absorption or utilization of the specific and anti-anemic principle.

It is apparent that the proper treatment is usually indicated if the study is complete. In the specific deficiency anemias the adequacy of treatment must be determined from the laboratory study of the patient's blood. No patient with pernicious anemia is adequately treated if a macrocytosis of the erythrocytes persists, and so the aim of treatment should be to obtain a normal color and volume index. Likewise in a case of iron deficiency anemia, if enough iron be given and if utilization is normal, the cells become larger and filled with hemoglobin, and the color and volume index return to normal.

REFERENCE

1. Haden, R. L.: *The Technique of a Blood Examination*. Jour. Lab. and Clin. Med., 17:843-859, 1932.

DISCUSSION

Dr. Robert A. Kilduffe (Atlantic City): To open the discussion on a paper by Dr. Haden concerning blood diseases, while at first glance a forbidding assignment, in the last analysis resolves itself into a very simple one. Dr. Haden's reputation as a hematologist is so outstanding that one may rest assured that any position he may take, or any proposition he may advance will be so well-founded in fact, and so amply buttressed by an array of accurate and pertinent data that, even if one were so disposed, there would be but scant opportunity of attacking its validity.

It would require greater temerity than I possess to contravert any of the propositions he has advanced here; and practically all that remains is to compliment him on the clear-cut, succinct and yet comprehensive and definite manner in which he

has outlined the classification of anemias and the excellent groundwork upon which this classification is based.

None of us, I am sure, will dispute the contention that the former classification of anemias, largely based upon purely clinical concept, is now out-moded and relatively archaic; just as none of us likewise will hesitate to agree that such a classification should be based upon laboratory as well as clinical data in addition to such etiological data as are available.

The classification Dr. Haden advances complies with all these requisites, and it is to be hoped that it will come into wide and general use which, of course, will depend upon the emphasis laid upon it by the laboratory worker and the interest which such studies will arouse in the clinician.

I can think of but one small point upon which there may be room for discussion, namely, the life of the erythrocyte, which Dr. Haden puts at about four weeks.

Since the discovery of the M and N agglutinogens followed by the preparation of potent and specific anti-M and anti-N serums, it has been possible to investigate this subject and to follow the life of transfused red blood cells. By means of this method, Landsteiner, Levine, and Jones⁽¹⁾ were able to recognize transfused blood cells for as long as seven weeks when their tests were terminated, while Wiener⁽²⁾ reports very recently upon studies demonstrating that the life of the transfused erythrocyte probably averages between 80 and 120 days.

This point, of course, in no way affects or invalidates the matter of Dr. Haden's paper and merely illustrates in another way the changing concepts in hematology inevitable as an aftermath of, and inseparable from, the newer investigations concerning the mechanism underlying blood formation, destruction, and regeneration such as those Dr. Haden so ably, so clearly, and so interestingly discussed here today.

It is always a pleasure to listen to one who not only understands his subject but is able to pass on that understanding to others. I feel privileged to have had this opportunity of hearing Dr. Haden.

1. Landsteiner, Levine, and Jones: *Prac. Soc. Exper. Biol. and Med.*, 25:672, 1928.
2. Wiener, A.: *Jour. Amer. Med. Assn.*, 102:21:1779, 1934.

PNEUMONIA IN CHILDHOOD

By WALTER B. STEWART, M.D., Atlantic City, N. J.

Read before the General Session of the Medical Society of New Jersey at the Annual Meeting in Atlantic City, June 7, 1934.

Under the title, Pneumonia in Childhood, it may be profitable to review with you some recent developments in the pathologic and the clinical aspects of this disease as it occurs during the early years of life. You are so well acquainted with the signs and symptoms that we need not spend much time with them this evening. The differences between lobar pneumonia and bronchopneumonia in the child are not as sharply defined as they are in the adult. Frequently one can not be certain which form is present. All degrees of transition between the two occur. Certain it is that lobar pneumonia develops in infancy much more frequently than was formerly believed. Engel maintained that it rarely occurs before the fourth month of life, but that it does occur with increasing frequency during the remainder of the first year and during the second year. This is contrary to prevalent opinion, and may be explained by the fact that the illness is relatively mild, the prognosis is good unless complications ensue, and few cases come to necropsy. Grulee and Mulherin had more cases of lobar pneumonia than of bronchopneumonia on a small pediatric service during a period of ten years. The youngest infant in the lobar group was two weeks old. But whether the diagnosis is lobar pneumonia or whether it is bronchopneumonia is relatively immaterial; the important fact is that it is pneumonia.

It is interesting to speculate on the pathogenesis of pneumonia. Why does the same organism in one instance cause lobar pneumonia and in another instance bronchopneumonia? Lauche has explained this on the basis of anaphylaxis; the exudative lobar involvement is an inflammatory reaction of the body sensitized to the protein of the pneumococcus. The sudden onset of the disease and the intensity of the reaction point to hypersensitiveness of the individual. This would account for the infrequency of lobar pneumonia during the first few weeks of life, be-

fore the body has become sensitized. However, congenital lobar pneumonia does occur and may be explained by the fact that the mother had had lobar pneumonia during her pregnancy, which was the situation in each of the nine cases studied by Lauche. The sensitivity was transmitted to the child by way of the placenta. Anderson and Pohl described the pathologic findings in a child who died soon after delivery and showed lesions typical of pneumonia which was undergoing organization of inflammatory exudate.

Recent work, notably that of Coryllos, has demonstrated that pneumonia is based on bronchial obstruction. Inflammation in the wall of the bronchus causes swelling of the mucosa and secretion of tenacious mucus, the combination of which bring about obstruction. The pulmonary tissue supplied by this bronchus collapses and the resulting atelectasis enables retained bacteria to become pathogenic and produce pneumonia in this portion of the lung. Considered from this point of view, lobar pneumonia, bronchopneumonia and atelectasis are of a common pathogenesis, depending only on the type and the virulence of the bacteria. Coryllos has substantiated these theories by bronchoscopic studies. Drainage of the occluded bronchus gives relief of symptoms in proportion to the amount of mucus aspirated and to the amount expectorated after the examination. The work of Yandell Henderson on the treatment of pneumonia by inhalation of 5 per cent carbon dioxide in oxygen has shown that the stimulation of the respiratory center opens up many of the collapsed areas and alleviates the symptoms. We are all familiar with those cases of pneumonia in which at first the presence of a foreign body is suspected because of the complete suppression of breath sounds over one lobe of the lung. Following the administration of an expectorant, the plug of mucus disappears and the signs of foreign body vanish.

Jahr and Hirsch have shown by roentgeno-

grams that during the preliminary stage of rhinitis and bronchitis before the onset of pneumonia there is swelling of the lymph nodes of the hilus. This is followed by passage of bacteria from the nodes into lymphatics leading out into the parenchyma and causing a circumscribed infiltration of the region about the nodes. This assumes a retrograde flow of lymph but may be explained by the dilatation of the lymphatics and the subsequent incompetency of the valves, and by the fact that the bacteria may grow rapidly along the course of the obstructed channel.

The pneumococcus is the usual etiologic agent of all types of pneumonia occurring during childhood; less frequently the streptococcus. In 88 per cent of one series of cases it was obtained on puncture of the lung during life. Many of the other organisms obtained from the lungs at necropsy are terminal invaders. Recent work on the pneumococci by Park of New York and his co-workers at the Bellevue and the Fifth Avenue Hospitals has shown that we must now subdivide *Pneumococcus* Type IV. into at least 25 types, each serologically distinct from the other. Type IV. formerly included from 80 per cent to 85 per cent of the pathogenic pneumococci of childhood, and Type I. only 10 per cent. Hence these new groups segregated from old type IV. are responsible for the majority of the pneumonias of infancy and childhood. Types I. and XIV. have been found more often the cause of lobar pneumonia, the former in children over two years of age, the latter in children under two years of age; and type XIX. more often the cause of bronchopneumonia. These three are the types of pneumococci found most often. Nemir at the Bellevue Hospital has given antipneumococcic serum of specific type to 82 out of a group of 207 infants and children, and has found the mortality rate slightly lower and the duration of the illness slightly shorter among those who received serum. The most striking results occurred with serum of types I. and XIV. Kereszturi and Hauptmann from the Fifth Avenue Hospital are less favorably impressed with their results in serum therapy.

There have been various classifications of

bronchopneumonia, but that suggested by Erich Nassau in 1926, based on clinical differences, appears most useful. He stressed the fact that bronchopneumonia in infants differs from that in adults, differs in symptoms, types and treatment, and that the inflammation of the lungs is only one part of a disease that is systemic. He also observed that the amount of the lung involved is not the factor that governs the outcome, since the loss of respiratory surface is seldom great. His classification includes the pulmonary, cardiovascular, atonic, alimentary, meningeal and septic types.

The pulmonary type of bronchopneumonia is that form whose symptoms and signs are limited chiefly to the lungs. Respiratory symptoms predominate and the prognosis is usually good.

The cardiovascular type, on the other hand, is characterized by cardiac failure and vascular collapse. Cyanosis and abdominal distention appear early. Dyspnea is pronounced, although there is little evidence of pulmonary involvement. The child is very restless. There are the usual signs of myocardial weakness. In this form of pneumonia one should avoid the use of stimulants, which would act on the heart as a whip on a tired horse. The use of some sedative, such as phenobarbital, and the intramuscular injection of a 10 per cent solution of dextrose is advocated.

The atonic type is similar to the cardiovascular except that extreme flabbiness of the skeletal muscles is present. The extremities become almost flaccid. There is marked asthenia and fatigue.

In the alimentary and the meningeal types extra-pulmonary symptoms predominate at first, and only later does pneumonia assert itself as the primary condition. The septic type with its fulminating onset, its muscular hypotonic and meteorism, and its cardiac failure usually comes to a rapid termination.

However, the form of pneumonia that is most peculiar to infancy and childhood is the aspiration type. We have mentioned already the intrauterine variety in which aspiration of infected amniotic fluid has occurred. The introduction into the bronchi of foreign bodies often induces pneumonia. The most frequent

offenders are dusting powders such as zinc stearate, peanuts, various oily substances, and regurgitated stomach contents. Heiman and Aschner induced a type of aseptic interstitial pneumonitis in dogs by the intratracheal insufflation of zinc stearate. A similar reaction may develop in the lungs of the child over whose face an open can of baby's dusting powder has been spilled.

The diagnosis of non-opaque foreign body, such as the segment of a peanut, in a main bronchus may prove difficult. Important diagnostic points are the sudden onset with violent symptoms, the suppression or absence of breath sounds over one lung or lobe of the lung, the signs of obstructive emphysema, and, most characteristic of all, an auscultatory wheeze over the involved lobe. The treatment is bronchoscopy.

During the last few years it has been brought to our attention by Laughlin and by Pinkerton especially that the aspiration of certain oils and fats also may cause pneumonia. This occasionally follows the struggles involved in the administration of oily substances to certain infants, the frequent feeding of premature infants by gavage, and the giving of large doses of nose drops with a mineral oil base. The oil runs down the wall of the pharynx into the trachea and lungs without producing the usual reflex closure of the glottis. To be sure, these unfortunate results occur but rarely, yet should put one on his guard. Not all oils have an irritating effect in the lungs: witness the frequent and apparently harmless installation of lipiodol, i.e. iodized poppy-seed oil, into the bronchial tree.

Pinkerton has shown that the droplets of irritating mineral oil are taken up in the alveoli of the lung by large mononuclear phagocytes and are transported by way of the lymphatics to the tracheobronchial lymph nodes. The removal from the alveoli is a comparatively slow process, often a matter of months. The end result, similar to that in the presence of any other insoluble foreign substance, is the formation of giant cells and the development of fibrosis. The microscopic appearance in one case actually suggested tumor formation. There have been many instances of the

development of tumor-like growths after the subcutaneous injection of camphorated oil and other substances with mineral oil as a base. The process of fibrosis in the lungs is often followed by acute bronchopneumonia and death. Pathogenic bacteria are carried in the oily substance from the nose and throat into the lungs. Perhaps also we may assume that normal saprophytes present in the depths of the lung are rendered active by the retardation of the action of the cilia lining the bronchi by means of the heavy oils or powders, thus establishing areas of lowered resistance.

These pathologic considerations lead one to a few prophylactic thoughts. No asthenic infant should be fed while lying flat on his back, thereby increasing the chances of false deglutition. Use great care in feeding infants by gavage. Give oily nose drops in small quantities and perhaps not at all to the weakly infant, certainly not for long periods of time. Some mothers will continue to use the nose drops uninterruptedly for weeks unless we advise them to the contrary. Avoid strummings and stranglings in the giving of oily medicaments by mouth. Be careful to warn the mother against the dangers of dusting powders, especially those which contain zinc stearate.

Finally, it is well to remember that most children with pneumonia, especially lobar pneumonia, are over-treated. Damage is done by unnecessary medication and too much disturbing of the patient. Give nature a chance. Open air treatment in a cool but not frigid atmosphere is superior to all other forms. It eases respiration, improves the circulation, and has a sedative effect. The inhalation of oxygen in certain cases, especially in the presence of cyanosis, is of value. The vague waving of an oxygen funnel to and fro before the child's face is worse than useless; the introduction of oxygen through a well placed nasal catheter or the use of the oxygen tent is the preferable method. Furthermore, we may avail ourselves of the inhalation of carbon dioxide in oxygen in not only the treatment of pneumonia but also its prevention. This method has opened up a new field for the treatment of atelectasis of

the new born. But above all, one should combat abdominal distention, the most serious early complication of pneumonia. If one can avoid or eliminate this condition, the outlook becomes much more favorable. Morphine should be used, in dosage proportional to body weight, when milder sedatives do not produce the desired effect. No child with pneumonia should be permitted to rave around deliriously for any length of time. Remember ipecac as an effective drug in dissolving obstructive bronchial exudate. Counterirritation is perhaps of value, a good form of which is the application of turpentine and olive oil sufficiently often to produce erythema. This is much better than a messy, mushy mass of mustard which cools too soon and interferes with the respiratory movements. Hydrotherapy is another method, the value of which is certain to provoke discussion. In a word, there are as many good methods of treating pneumonia as there are capable clinicians, and in the hands of each the result will be about equally good or bad, provided only he remember the aphorism: "Primum non nocere"—"First of all, nothing harmful".

DISCUSSION

Dr. Arthur M. Dannenberg (Philadelphia, Pa.): The advantages of hearing Dr. Stewart's excellent paper are many. Not only does he review the more recent concepts of the pathogenesis of pneumonia, but he outlines in a clear manner the clinical manifestations of the disease. Particularly to the general practitioner should the latter be most helpful. It teaches him that in early life the lobar pneumonia that presents pure respiratory symptoms is not the fearsome disease that it is in adults. In such cases, the prognosis is good. Only in extremely malnourished children and in instances when it occurs as a complication or terminal event of another illness, is it a dangerous disease.

Dr. Stewart's paper is so inclusive that it is difficult for me to decide what part of it to discuss. Perhaps the best that I can do is to emphasize what he has said with regard to treatment. It is true that there is a tendency to overtreat the average case of pneumonia in infancy and childhood. This does not obtain in the hospital ward where parents are excluded, but in the private home. Here the physician must satisfy the parents that he is actually doing something for the sick child. Especially does this apply to fever. We know that fever is nature's effort to overcome an infection, as it stimulates leucocytic activity and anti-body formation. To the parents, however, it is the all

important part of a disease, and they implore the physician to reduce it. As a consequence, routine sponging is ordered, when the temperature reaches an arbitrary point set by the physician.

I have never been convinced that such treatment is beneficial. It may annoy the child and interfere with much needed rest. Only when the fever causes extreme restlessness and delirium are simple hydrotherapeutic measures indicated. As Dr. Stewart emphasizes, these can be combined with sedative drugs of which opium and the barbiturates are the best.

Empirically, counter-irritation has been used in pneumonia for ages. When I was an interne twenty years ago, pneumonia jackets and cupping were in vogue, as well as the ubiquitous mustard plaster. Clay preparations plastered over the chest wall were also more or less popular. It is extremely doubtful if such therapeutic measures can modify in the least the pathology that occurs in a pneumonic lung. Their use certainly adds to the patient's discomfort, and by their weight alone increases respiratory efforts. The only indication for counter-irritation in pneumonia is pleuritic pain. Then the simple olive oil turpentine preparation is as good as any.

The problem of feeding a sick infant or child is a very real one. I think too much emphasis is placed on food intake. It is practically impossible to make a toxic child suffering from any febrile disorder take food sufficient for its theoretic caloric needs. Fortunately it is rarely necessary to do so. It is well to remember that the fat and muscle mass of the body is in itself a tremendous source of potential energy that can be utilized temporarily to maintain vital processes until circumstances are favorable for the ingestion of food. Because of their taste, sugars are usually given with little difficulty. From the physiological standpoint, they constitute the food of choice in practically all febrile conditions, when digestive processes are impaired. They are easily assimilated, spare body protein breakdown, and by their conversion into glycogen in the liver, help this organ in its great detoxifying function. In addition to these virtues, sugars supply the energy to maintain adequate muscle contractions, not only of the skeletal muscles, which concern us little in pneumonia, but of the diaphragm, the intercostals, and most important the heart muscle. Personally I give lollipops or other hard candies, when conditions warrant. An intra-muscular injection of a 10 per cent glucose solution as recommended by Dr. Stewart is an excellent method of supplying quickly available energy to a flagging heart muscle.

While except for sugar, food is not so necessary, the body can not be deprived of water for any length of time without serious results. An adequate water intake must be maintained. This is rather difficult in severely toxic and delirious patients. It is not much of a problem in the hospital where venoclysis or hypodermoclysis outfits are readily set up, and measured quantities of normal saline solution containing 5 per cent to 10 per cent dextrose can be given. In the private

home, however, such measures are not always possible. The ingenious and careful physician can set up a hypodermoclysis outfit made up of an irrigating can, rubber tubing, and a large hyperdermic needle, and get as good results as with a more elaborate equipment. Enteroclysis can be given, but in my experience, has proven unsatisfactory. Gavage is an easy and satisfactory method of administering fluid as well as food, provided it does not provoke vomiting and excite the patient too much.

Cyanosis in pneumonia is of grave importance. It is best combatted by the inhalation of oxygen. Dr. Stewart has told you of the futility of waving an oxygen funnel to and fro before a child's face. Placing a child in a modern oxygen tent is really the best method of relieving cyanosis. As this is not always available, oxygen administered through nasal catheters may be substituted. There seems to be an impression among some physicians that all cases of pneumonia should be placed in an oxygen tent if possible. The only value of an oxygen tent is to relieve cyanosis and severe dyspnoea when the latter is not due to pain. It may be of some use in hyperpyrexia.

Dr. Stewart has wisely refrained from advocating any specific drugs in the treatment of pneumonia. It is always interesting to me to learn of the various drugs which are so confidently used. A former chief of mine is still enthusiastic about the use of quinine in pneumonia. I have seen him give this drug in enormous doses to his little pneumonic patients without being convinced that it modified the course of the disease in the slightest degree. Other physicians routinely give ammonium salts in an attempt to dissolve the pneumonic exudate. The futility of such a therapeutic measure is apparent if the pathology of the disease is understood. I admit to therapeutic nihilism in this disease. My experience with specific sera is entirely too limited for me to draw any conclusions as to their value. Blood transfusions are desirable in properly selected cases. Let us hope that the treatment of pneumonia with artificial pneumothorax recently tried at the University of Pennsylvania Hospital may prove of value.

Until we know more about the treatment of this disease, I can best end my discussion by quoting from Dr. Stewart's paper:

Primum non nocere—first of all, no harmful therapy!

CURRENT PROBLEMS IN SCHOOL HEALTH WORK

By ALLEN G. IRELAND, M.D.,

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Public Instruction

Read before a Joint Meeting of the Sections on Pediatrics and School Physicians of the Medical Society of
New Jersey at the Annual Meeting in Atlantic City, June 6, 1934.

The term problems as used here does not necessarily refer to unsolved difficulties, but rather to current trends, events, or situations peculiar to school health work. While some are truly problems in the sense of being troublesome, others are steps or developments in an evolutionary process.

STATUS OF SCHOOL PHYSICIAN

The question of the school physician's status is receiving more attention than ever before. We see it in the transition which marks the distinction between "medical inspection" and "the school health program." The former is narrow both in concept and practice, while the latter is broad in scope, an integral phase of education, and more truly definitive of the physician's contribution to the school. Throughout the nation the term "school physician" is gradually replacing the older term "medical inspector." Similarly, the trend is

to recognize the physician as a regular member of the administrative staff of the school. Though he is usually employed for part-time, he belongs nevertheless to the staff of consultants or experts which the head administrator requires to operate the system effectively. He is employed because of his special training, experience, and talent to advise the administration at all points where the question of child health is involved. This concept insures coöperation and results; and the principle is identical with that which justifies the employment of architects and engineers in industry, of accountants in business, of experts in government, and of physicians in the military establishment. No longer should we think of the doctor as independent of organization, nor should the doctor regard the school as just another call on his round of daily visits. Too long it has been that way, and to both the results have been unsatisfac-

tory. Now we sense a "get-togetherness" taking place, a teaming-up in the interests of the child and of society. At last, the physicians' talents are being purchased, not merely to inspect children nor to administer medical care, but to make the school a healthful place in which to live, work, and play, and to help construct a school program that is compatible with the mental and physical capabilities of children at the several age levels. Only in this way can the physician make the most of his opportunity to help the school attain the ultimate aim of education, that of perpetuating society upon ever higher levels of living.

SCHOOLROOM SANITATION

A problem that is always with us is represented by the breach between the findings of modern science and the traditional practices of the school. It is not one problem but many, and its ramifications affect all phases of child-life—mental, physical, moral, and social. Space permits only a few illustrations here. Lighting, heating, and ventilation are prominent instances. Thus, we learn that most schoolrooms have inadequate light, both natural and artificial. From this cause pupil performance is often below standard; there is economic waste; the effect may be depressing; and eye strain is increased. Room temperatures are invariably too high, giving rise to irritability, drowsiness, slouchy postures, mental sluggishness, not to mention dryness of the nasal and pharyngeal mucosa, in both pupil and teacher. In many schools noise is a disturbing factor, although its effect is subtle and hard to measure. Old-fashioned drinking fountains are still too commonly found. In stormy weather, wet outer garments are massed in compact compartments or wardrobes without ventilation, and where the normal circulation of air has no chance. Proper seating, with both chair and desk adjusted to the pupil, simple as it is, is not the rule; but without it there is discomfort, restlessness, and fatigue.

EMOTIONAL EXPERIENCES

On the mental and emotional side, the faults of school procedure are beginning to be understood. To certain children doubtless more in

number than we realize, the recitation is a terrifying experience when conducted as a mere measure of knowledge. It may be the starting point of those feelings of inferiority and fear of ridicule which cause some children to hate school. The same is true of grading schemes, examinations, and competitive devices. In too many of these situations, the emphasis is upon failure rather than success. As a result, certain types of children become easily discouraged. They create every manner of excuse to leave school. Glorifying education has no effect, because the future is not so close and real as the daily realities of the schoolroom. Instead of eager curiosity and the normal desire to learn and do, there may be fear, fantasy, withdrawal, or morbidness. It becomes easy to practice deceit and to create a defense wall of misbehavior in various forms. Normal interests are warped and submerged. And in the end both the individual and society pay dearly. True, the recognition of this aspect of health represents a great advance. We are learning daily what it means and where our work lies.

Physicians can render invaluable service in this direction; first, by making themselves familiar with the psychological phase of health education; second, by helping to sort out the neurotic and emotionally unstable children; and third, by consulting with the administrator on measures of prevention and correction.

It will suffice to merely mention tuberculosis as a problem of the times, because we already recognize its existence and seriousness and a counter movement is well under way.

With the successful advent of "the public health hour," as recommended by the Public Health Committee, it is believed that the problems centering around immunization are well on the way to solution. At any rate, it is urged that all school physicians give the experiment their earnest support and a fair trial.

HEALTH OF TEACHERS

The adult personnel of the school presents a health problem that is gaining recognition, though little has been accomplished in the way of a solution. Gradually, however, favorable support is gaining momentum in the form of

public opinion. Boards of education are becoming cognizant of a responsibility to protect children, and parents are beginning to speak knowingly of the healthy teacher or janitor. A few school districts require either annual examinations of teachers by school physicians or the presentation of a health certificate from a practitioner of choice. For the most part, such efforts are perfunctory, as would be expected in the early stages of development. What will result ultimately is difficult to foretell with accuracy. We must rely upon evolution, science, and common sense. In the meantime, it behooves every school physician to study the problem locally, and, at every opportunity bring it to the fore. Sick leave with pay is one device deserving consideration. Though it breeds certain evils, it can be made to function satisfactorily. Giving more emphasis to the health factor in the selection of teachers and in the recommendation of normal school selections for training is important. Physicians should defend this point, and what is more significant, put it into practice in the case of high school seniors who choose teaching for a career. Physicians can help too by giving interesting talks to teachers, stressing health as a factor in efficient work, happiness, economy, and effect upon pupils. The annual examination should be endorsed, and special stress should be given to the necessity for determining the presence or absence of tuberculosis. In all these efforts, cafeteria workers, especially food handlers, janitors and others should be given the same attention as teachers.

ATHLETICS

The field of athletics is one the school physician may look upon with justifiable concern, and often with alarm. Not the sports of the school day nor the recreative activities for the mass of pupils, but the highly organized competitive team games of interscholastic athletics demand the best professional scrutiny we can give. In particular, any effort in junior high schools to imitate the athletics of sen-

ior high schools and colleges should be curbed at the outset, for once "blood is tasted," so to speak, and the hysteria of victory is felt, prohibition becomes a most difficult administrative problem. These young boys and girls are still in the period of rapid and irregular growth. They are neither physically constituted to withstand the strain of strenuous athletics, nor mentally matured to the point where competition with victory or defeat can be viewed in the true spirit of sport. It should be understood by school physicians that the State Department of Public Instruction does not recommend interschool contests for junior high school, but, instead, it does everything within its authority to oppose such developments. Moreover, the Department is ever active in seeking a reduction of emphasis upon athletics in senior high schools. On this point, a platform of sane standards has been recommended.⁽¹⁾

GUIDANCE WORK

An interesting and far-reaching development in education is known as guidance or personnel work. It applies principally to high schools and it is rapidly becoming a major administrative unit with a trained staff and a special program. In brief, it represents an attempt to study the individual—his interests, abilities, aptitudes—with a view to guiding him into courses of study, vocations, social adaptations and the like where he is most likely to be happy and to succeed. Gradually the health implications are gaining prominence. Mental and emotional factors in the health complex are obvious, but now counselors are becoming conscious of the influences of physical handicaps, particularly in the selection of vocations. As a result school physicians are being called upon with increasing frequency to coöperate and to participate actively in guidance work. A tentative glimpse into the future reveals great possibilities. There appears to be opening up a new and vast field where medical service will perhaps make its greatest contribution to education.

ARTHRITIS CONSIDERED AS A SYSTEMIC DISEASE

By REGINALD BURBANK, M.D., New York

Read before the General Session of the Medical Society of New Jersey at its 168th Annual Meeting, in Atlantic City, June 6, 1934.

It has been said that arthritis is infection plus X; but so many values have been given X by so many students of this subject that one is in the position of a man trying to solve an algebraic problem with many unknown quantities and too few equations.

If one attempts to approach the study of this disease from a different point of view than that usually accepted, it will make the evaluation of our variables simpler and allow definite correlation of what are otherwise apparently completely divergent theories.

Since 1885 various strains of cocci have been associated with the production of the non-specific arthritides, but research workers have not been able to come to any agreement as to causation because of the fact that nearly all have attempted to lay the blame on some particular strain of specific arthrotropic organism.

The consensus of opinion at the present time tends more and more strongly to consider arthritis not as a disease of the joints, but as one of the possible end results of chronic infection with streptococci the major invading organisms.

The masterly early investigations of Poynton and Payne laid the blame on a diplococcus. Rosenow showed definite selectivity in various strains of streptococci more or less morphologically similar. Crowe considers a staphylococcus albus to be the chief cause of arthritis deformans, but feels that streptococci also necessarily enter into the picture. Cecil and his co-workers maintain that a typical strain of green-producing streptococci with a hemolytic auriole is the chief cause of the rheumatoid type. Small stresses a nonhemolytic streptococcus as a causative organism. Clawson and Wetherby lay the blame on low-grade viridans strains. We have felt that there is no specific single strain, but that streptococci which have developed the power to ferment mannite and live in a comparative oxygen deficiency can produce arthritic lesions. The mention of these few divergent opinions by no means covers the

field, but merely serves to illustrate the wide variance of findings among a group more or less in accord.

Some take the stand that infection plays little if any rôle, except secondarily, in the production of arthritis. Swift and his co-workers consider the allergic element to be the chief factor in the production of the disease, with actual bacterial invasion of the tissues as secondary or even negligible. Duncan, Thompson and many others blame endocrine dyscrasias. Pemberton and Fletcher, to mention only two, consider faulty diet the real causal factor. The Boston school, headed by Goldthwaite and Osgood, stress posture and mechanical strain. Ely and a number of Californians lay the blame on amebae. A complete list of causal theories would be far too long for a short paper, but when reliable men report favorable results with treatment formulated from such divergent methods of approach, one certainly cannot cast the work aside as irrelevant. There must be some way of reconciling such findings and fitting the various theories together so that they will clarify the picture instead of obscuring it.

When we consider arthritis as one of the possible end-results of infection, we find a close resemblance to such diseases as syphilis and tuberculosis where a basic infection of low virulence can produce end-results as different as is the secondary rash from a Charcot joint, and lupus from Potts disease. We know that the tubercle bacillus is not of uniform stability, and the work of Mellon has shown that there are many dissociations in its cycle. The same will probably be found true of the spirochete pallida and our work with the streptococcus has confirmed our long-standing belief that these organisms are capable of adaptation to varying immunological resistance and altered oxygen tension.

Formerly, we were unable to reconcile the fact that the apparent primary focus of infection rarely showed a streptococcus similar in

type or in sugar fermentations to that isolated from joint tissue at biopsy, but we now feel that the adaptation of the organism to changed conditions such as are found in the intestinal tract and joint tissue can explain the low virulence of an arthritic infection since, in order to survive, the primary focal strain has to forego its highly invasive character and become more parasitic in nature so that it can live its life cycle without arousing strong immunological resistance on the part of the host.

Streptococci that enter the blood stream may retain their hemolytic or viridans reactions to blood, or may become indifferent in type, but in order to become joint invaders they have to develop the ability to ferment mannite and live in a relative oxygen deficiency. Such an adaptability explains the many divergent findings and shows why focal strains nearly always differ from those actually found in the blood stream and in biopsy cultures from joint tissues. Changes occur which reduce chain formations to diplococci and we have definite dissociation into diphtheroids and even into staphylococcic groupings similar to the micrococcus deformans described by Crowe. Such radical dissociation phenomena are not considered possible by some of the orthodox bacteriologists, but such recent work as that of Calow and our work of the past eight years has substantiated our original belief that morphological changes and altered sugar fermentations are not only possible in the test tube but in the human as well.

The theory that the streptococcus is able to alter both morphology and invasiveness according to the immunological resistance of the host seems a much more tenable one than that presupposing a super-imposed infection whenever such a flare-up as a rhinitis, nasopharyngitis or tonsillitis occurs.

We all know that the streptococcus is ever with us, in more or less saprophytic form, and we feel that invasion by it is permitted only when the active resistance of the host is depleted.

As a refutation to the theory of streptococcic infection as a causal factor in arthritis, the statement is frequently made that non-arthritics show complement fixation with various

streptococcal strains and that streptococci and diphtheroids with capability of mutating into streptococci are not infrequently cultured from the blood of normal individuals. When we consider arthritis as one of the results of infection, such findings are merely an indication that large numbers of apparently symptom-free individuals are potentially arthritic and only need the addition of the unknown X to bring about joint involvement.

We firmly believe that this unknown may be sensitization, endocrine dyscrasia, dietary indiscretion, buffer salt deficiencies, depletion from some intercurrent cause, mental and physical trauma, faulty posture and so on, *ad infinitum*. The gun is already loaded and any one of these may pull the trigger.

It is difficult to conceive that such a widespread affliction can be caused by anything but an omnipresent organism which has the ability to adapt itself to a satisfactory existence without arousing violent immunological reactions on the part of its host. A brief attempt to correlate some of the apparently divergent theories will give greater clarity to the arthritic picture.

That allergy plays a rôle can be demonstrated by the fact that many patients are definitely relieved by desensitization; but unless we consider a gonorrheal joint an allergic manifestation, we can see no reason why a streptococcic joint should be so considered when many investigators have been able to isolate the organism from joint tissue and even demonstrate it *in situ* by special cultural methods.

Endocrine dyscrasia may undoubtedly have a definite bearing in arthritis, but many endocrine disturbances seem to be rather a result of infection than the cause of the arthritis. In other words, the same causal factor that is productive of endocrine involvement likewise produces arthritic joints.

Dietary indiscretion unquestionably allows a more prolific growth of streptococci in the intestinal tract, and these organisms can more easily become invasive when fermentive processes produce irritation of the intestinal wall and destroy the defensive integrity of the mucous membrane.

Faulty posture is responsible for many cases of chronic constipation, and when retention of fecal matter persists, not only are the organisms of arthrotropic potentiality allowed to multiply more freely, but the intestinal wall is irritated by the stasis to a point where its permeation becomes less difficult. Posture that is faulty likewise produces constant low-grade trauma and renders such irritated areas more open to invasion.

Buffer salt deficiencies can be considered a result of infection rather than as a basic cause of arthritis. We are all familiar with the increased phosphorous elimination and the definite calcium imbalance that so frequently go hand in hand with chronic infection.

The amebae are characterized by their ability to produce ulcerations of the intestinal mucous membrane, thus allowing ready systemic invasion by the streptococcal inhabitants of the intestinal tract.

Arthritis has been experimentally produced by repeated trauma such as is aroused by introducing foreign bodies into a joint cavity; but the work of Fisher has shown that arthritic manifestations occurred much more quickly and were more typical of arthritic lesions as found in the human when streptococci also were introduced; and how are we to exclude

the presence of this omnipresent organism even when they are not experimentally added?

Typical arthritic lesions can be produced in rabbits with mannite-fermenting strains of streptococci isolated from the blood stream of human arthritics with almost uniform regularity. These organisms can be re-cultured from the arthritic rabbits and similar lesions produced on re-inoculation into normal rabbits. In these arthritic lesions we have been able to demonstrate the presence of streptococci of hemotogenous distribution in all joint tissues except cancellous bone and cartilage without blood supply.

Since such uniformly positive findings can be obtained with streptococci, and since experimental arthritis is either impossible of production or extraordinarily infrequent in occurrence when any other method of approach is tried, we will continue to hold to our belief that streptococci that have developed a high degree of civilization are the sine qua non of that end-result of infection called arthritis.

The microphotographs which we will now show on the screen will demonstrate our joint findings, and we will also attempt to show that dissociation forms of streptococci can be demonstrated both from test tube cultures and those made from the human arthritic joint.

DISCUSSION

Dr. B. L. Buzby (Camden): I have listened with interest to the correlation of all arthritic theories, especially with relation to infection being the basis of all with trauma, metabolic disturbances, diet, allergy, etc., being the trigger finger to pull the loaded gun.

Clinically each case is a law unto itself and must be evaluated according to the many potential causative irritative agents.

I agree that the streptococcus is almost universally the infective agent regardless of whether or not it may be morphologically changed into diplococcal or diphtheroid forms or sarcinae upon lodging in a joint from the primary focus, but postural defects, metabolic disturbances, gastro-intestinal stasis, dietary indiscretions, etc., must be entirely corrected before we can hope for complete relief of symptoms even after elimination of all foci of infection and subsequent vaccine therapy.

Again we must not lose sight of the fact that a seriously infected joint may continue to be the source of systemic infection and may be relieved only by synovectomy—eg. Bender, 35 years old with teeth, tonsils, appendix and hemorrhoids out, still

progressed with involvement of one knee, opposite ankle, both elbows, one wrist and hand after three years.

The knee joint seemed the worst affected, so a synovectomy of this joint was done with subsequent vaccine therapy from culture from the tissue thus obtained frequent previous aspirations obtaining no growth, and after three months the man returned to work without symptoms and without swelling, although some limitation of motion still exists in some joints.

Some patients demonstrate multiple predisposing causes, eg. so-called menopausal arthritis, where obesity, endocrine changes, postural trauma and peripheral blood vessel changes all play a part and each must be brought back toward normal before bacterial treatment is of value.

Atrophic or proliferative arthritis, while not mentioned as such in the Doctor's presentation, would seem to me to have to be classed still in the non-infectious category, because of the rarity of recovery of organisms from the joints and the continued progress of the disease clinically in spite of anti-bacterial therapy of various kinds.

Of the various vaccines offered, by all odds the best results in treatment are obtained by specific ones made from the organisms obtained from the infected joints and *not* from potential foci of infection as teeth and tonsils, which to my mind are purely "shot gun" attempts to increase immunity. Of the other vaccines those with which I have had best results in the order named have been Wetherby Intravenous, Coleys Fluid, Parke Davis Intravenous (a shot gun combination of organisms isolated by many investigators), Smalls Serum, and lastly the vaccine made from the suspected distant focus.

Avoid general reactions but obtain local heat subjectively, if possible. Physiotherapy begun early and kept up actively is of great value, but all progress may be upset by metabolic disturbances and external influences, eg. excessive use, strain, cold.

Again I wish to express my thanks to Dr. Burbank for the privilege of listening to and discussing his comprehensive report on a subject which is of great interest to us all and one about which our knowledge is becoming more and more widely understood and appreciated.

Dr. John W. Gray: There is so much diversity of opinion among reliable men regarding the etiology and treatment of arthritis that the correlation of these apparent divergent theories is refreshing. Dr. Burbank's conception of rheumatoid arthritis as the end-result of a systemic infection with numerous "X" factors playing a large part in the clinical picture, places the etiology upon a sound basis.

Dr. Burbank's bacteriologic studies, while differing somewhat from those which I have conducted, lead to the same conclusion; that streptococcal infection is the chief cause of the disease and that joint tissues tend to become infected. Streptococci found in the upper respiratory tract or intestinal tract of arthritic patients may or may not be pathogenic. The reaction of the patient to such organisms must be studied in order to determine that fact. On the other hand, pathogenic organisms may be present in the mucous membrane of normal individuals and never gain a foothold sufficient to produce toxic or infectious symptoms. If, however, focal infection occurs, the absorption of toxins may produce an allergic type of arthritis, or bacteria entering the bloodstream may localize in the joints, establishing numerous new foci.

In a well-established case of rheumatoid arthritis I am of the opinion that bacteria have not only entered the bloodstream but have also localized in the periarticular tissues. This opinion is based upon extensive cultural studies of foci, the blood joint fluid and joint tissues.

We have been unusually fortunate in isolating streptococci from the blood in a large percentage of arthritic patients. Although as a rule a definite strain was found, there were rare instances point-

ing toward mutation and the adaptation of the organism to changed conditions in the host. It is of considerable practical interest that our percentage of positive cultures was low during the summer months, and that in Tucson, Arizona, positive blood cultures are seldom found. Apparently under such conditions the incidence of upper respiratory infection is decreased, the patient's resistance is increased, focal and joint infections become less active and the frequency of bacteremia is quickly reduced.

In the treatment of rheumatoid arthritis it is obvious that we must take into consideration not only the underlying infection, but also all of the "X" factors in order to satisfactorily solve the patient's "algebraic problem".

General supportive measures, including rest, freedom from worry, sunshine, nutritious diet rich in vitamins, transfusions, etc., may or may not be sufficient to control the joint infection. No additional form of treatment which may tend to check the progress of infection and prevent joint disability should be neglected or postponed.

In my experience, vaccine has proven to be a valuable adjunct in treatment. It must be prepared from a suitable organism, i.e., one having some relationship to the infection. It must be administered in small doses and for a long period of time. Reactions should be avoided. In rapidly progressing cases, it is obvious that considerable joint damage may occur before the infection can be arrested. Allowance for remissions of the disease should be made in evaluating the beneficial effect of vaccine or any other therapy.

Focal infection requires careful attention. It would be ideal if the primary focus could be removed before bacteria reached the joints and localized there. On the other hand, operative procedures while the patient is in a depleted state may, through further lowering the resistance and increasing bacteremia, may be the starting point of joint localization, or make joints already involved a great deal worse.

In this climate where the incidence of rheumatoid arthritis is so high and where the economic loss is so large, there should be some concerted action taken for providing adequate treatment for all patients. A very small minority of this group of sufferers is able to secure the proper treatment. This country is practically without institutional facilities for the treatment of arthritic patients. They need the "rest cure" as much as those suffering from tuberculosis. They need physiotherapy for the maintenance of muscle tone and joint function. Many cases require hydrotherapy and muscle training similar to that used for the rehabilitation of poliomyelitis cripples. Therefore, specially equipped hospitals and sanatoria are very much needed for the adequate treatment of Rheumatoid Arthritis.

THE PROBLEM OF MEDICAL PRACTICE

By JOHN A. HARTWELL, M.D., New York

Delivered before the Morris County Medical Society, June 21, 1934

It is quite apparent, I believe, to all thinking members of the profession that the time has arrived when they must give individually and collectively, serious thought to the trends in medical practice.

In accepting the honor which you extended to me to appear at this meeting, I was impelled by the fact that it has long seemed to me that your State of New Jersey is ideally situated to grapple with this problem rather better than most of the states in the Union. I am further convinced that this may be true because on my several visits to this side of the river I have been impressed with the fact that the New Jersey profession is far less influenced by emotional viewpoints than some other sections of the country.

JUDGMENT, OR EMOTION

It would give me very great satisfaction if I could present to you what I would consider a constructive solution. Unfortunately, I cannot at this time because in my belief, there is not a sufficient knowledge of many important facts to make this possible. There is one constructive statement, however, which I feel at full liberty to make, namely, that not only the leaders, but the rank and file of the profession must give this topic serious study and must not be influenced by an emotional or resentful trend. I use these adjectives deliberately because I note in very many of the writings and in many of the discussions a tendency to employ both.

To my mind, this important matter can only be settled by judicious consideration of the fundamentals at stake. If either the laity or the profession allow themselves to be influenced by anything else than a judicial consideration of the facts and careful reasoning therefrom, the best solution cannot be reached.

What then, is the problem? It seems to me that this can be formulated rather simply. *A growing consciousness of the value of health*

is a very definite trend of the body politic. How much of this is based upon *economic* considerations and how much is based upon considerations of the *heart*, is impossible to say. That both factors enter into it is quite apparent. Industry is more and more taking steps to procure good health conditions for its employees. The railroads, great manufacturing concerns, large commercial undertakings, banks and the universities are all to a greater or less extent providing some kind of health protection and service for their employees and students.

In the case of the universities, it may be argued that they are moved by other than economic considerations and have in mind the rendering of service not only to students but to society as a whole.

In the case of the others, however, it is the economic factor that is uppermost, and medical service is provided and paid for because employers are satisfied that they receive a return in kind therefor.

On the other hand, the state, well fortified by public opinion, is spending greater and greater amounts upon the care of the insane, the tuberculous, the victims of hopeless malignant diseases, and other sufferers from whom no possible productive return can ever be expected. This is done because *society will not tolerate suffering* if it can be avoided. Society, therefore, pays the bill in order to have peace of mind. The conditions 50 years ago in our insane asylums and homes for the feeble minded were repugnant to society; and therefore, the means have been found to improve these until now the care of patients in these institutions affords them, except for their mental disability, far more happiness and satisfaction than many of them could get if they were not afflicted and had to cope with the struggles of the outside world.

Therefore, whether motivated by considerations of the pocket or feelings of the heart, more and more is it an accepted belief that

ill health must be eliminated both collectively and individually insofar as it is possible.

MEDICAL SERVICE THE CONCERN OF THE PUBLIC

This being the case, it is futile for the medical profession to argue that the care of the sick is their concern and theirs alone. The laity not only is equally interested, but it is exceedingly active through one channel and another in demanding that medical practice shall be so conducted that individuals will have good medical service.

Concretely, therefore, the problem is this: How shall the commodity which the medical profession possesses be delivered to society so that, insofar as medical knowledge is capable of preventing and relieving disease, this end will be attained? It will be helpful if, in attempting to answer this question, we have it clearly in mind as to how this has been done up to the present time.

THE FEE SYSTEM

In case of those who are financially able to do so, a private arrangement has been made between the patient and the doctor for the purchase of this commodity. The amount to be paid therefor has been personally arranged between these two, and as we all recognize, it has been arranged upon a sliding scale depending upon many factors which it is not necessary to detail before a medical group. This sliding scale has included a large number of persons who it is fully understood were paying only a small part of the actual value of the service rendered. In a considerable proportion, the price was far below the actual cost to the doctor.

This sliding scale, however, could not be brought to the point of taking care of those in the lower economic brackets, and consequently, these patients have been considered a charge on society and have been taken care of in free out-patient departments, or free beds supplied either by private philanthropy, or by public taxation. In either case, it has been customary for the doctor to receive no

return for the commodity he was furnishing to this group.

When the practice of medicine was a comparatively simple matter with inexpensive equipment, a short period of training, and a very small overhead expense, this fee method of payment for services was fairly satisfactory in meeting the needs of society and giving the doctor a sufficient return to justify his endeavor. With the conditions that obtain at the present time relative to the great expense, the long period of education, the expensive equipment, the high overhead, and the increased demand on the part of patients because of the increased service that must be rendered to them in order that their needs may be served, this method has become inadequate to meet the situation.

Various devices have been adopted as compromises, but there has been no definite outlined policy of procedure taking into consideration all the elements involved.

FREE MEDICAL CARE

Gradually a larger and larger portion of the population has availed itself of free or practically free facilities, and the doctor has been called upon to render more and more service without compensation.

As was pointed out by Professor Bossard in the recent meeting at Philadelphia in his address "A Sociologist Looks at the Doctors", two very important educational factors have been at work to develop a new point of view on the part of our public. The first has to do with the fact that children attending the public schools and the parents of these children have become accustomed to getting a great deal of free service through public channels connected with the educational system. They have been impressed with the fact that this was furnished them by public authorities just as their education was. Fifteen years ago, this same group passed out of the schools and into the army at the time of the World War. Again they found themselves recipients of the best medical care for which they paid nothing. Upon their discharge from the army when confronted with a need for medical

care, they asked why this also should not be furnished as a free commodity which they had so long enjoyed, and much of the veterans' legislation for this was stimulated by this point of view.

Again, as pointed out above, industry and commerce and various other activities give medical service as a part of the return from employment.

As a result of these influences there is gradually growing up a feeling that the individual is entitled to medical care at someone else's expense, just as he has been trained to believe through many generations that he and his children are entitled to educational facilities.

Dr. Brossard is probably right in believing that this attitude is an important element in the present pressure for a review of the relations between the doctor with his commodity of medical service and the purchaser in society.

Whether this is an important factor in the present attitude or not, it cannot be denied that the attitude exists; and that, therefore, the doctors are faced with great difficulty in obtaining adequate payment for their commodity from the individuals who receive it. Since there is a growing feeling that health is a public concern, the doctors have little ground to stand on if they assert that they will deliver their commodity only upon their own terms and will not be concerned by the viewpoint of the purchaser thereof.

DEVELOPING A PLAN FOR PAYING FOR MEDICAL SERVICES

Under such circumstances, the wiser course for the medical profession is certainly to look the facts squarely in the face and attempt to evolve a plan for disposing of their services, the commodity, in a way that will meet present conditions. If they fail to do this, it can but result in conditions of sale which will be forced upon them from the outside just as has been the case with so many other commodities which the public needs in large amounts, as for example, all public utilities, transportation, and similar services.

In your own state the profession has taken

cognizance of this situation and I am informed that in Morris County much has already been done.

As I stated at the beginning of this talk, I regret that I am not able to present to you a solution for the present difficult situation. It does seem to me, however, that the solution lies within the hands of the doctors in any given community provided they will recognize the necessity of a solution, will study the conditions under which they are working, and will make an honest effort to meet the requirements. That objective, however, must be clearly understood.

In my belief, society is more and more requiring that the commodity of medical service shall be made available to all classes of people.

So far as I know, no one has advocated a change in the relations between the doctor and the sick or healthy individual *who is able to pay* a proper return for medical service.

Nor has anyone seriously advocated that the present plan of taking care of the completely *indigent* shall be abandoned. They are public charges and must be taken care of at public expense. Proper consideration, however, has not been given to the expense connected with the medical service rendered to such indigents by the doctors. Doctors have been willing to render this service without compensation in the past because the opportunity to do so was held as of sufficient educational value and enhancement of prestige to pay for the service. It is questionable whether this is longer a tenable position; and it is incumbent upon the doctors to discuss with the authorities and tax payers the wisdom and the justice of receiving in some form compensation for the care of these public charges. Again, probably this must be worked out in a different way in different communities; but it should not be left in its present haphazard condition with its tendency for those above the economic grade of indigency to become a part of the system.

THOSE IN MODERATE CIRCUMSTANCES

The crux of the problem, however, lies in that great group which fills the economic space

between the two above classes, namely, the well to do, and the indigent. After all, in numbers these are far greater than either of the other groups. In total paying capacity they are also above the other groups. By and large, they are the ones who are the maximum purchasers of any commodity. It is, therefore, from them that the medical profession as a whole must draw its financial support.

What then is the difficulty in furnishing the doctors' commodity to this group of purchasers? The difficulty lies in two general facts. The first that under the best of conditions this group economically has a rather hard position in meeting their financial responsibilities. Whether this is due to lack of sufficient income or lack of ability to make that income yield the greatest return is hardly germane to the question. In dealing with any situation, it is necessary to take into consideration the habits and trends of thought. The great majority of this class are not strictly careful in establishing a budget. Even if they do, they have little information on which to include the cost of medical and dental care of an average year, and since the human being is optimistic, these items are not given serious consideration because it is hoped that no illness will occur in a given year.

In this relation also, as just pointed out, if serious consideration is given to the question of sickness, there is an underlying thought that it will be managed in some way at the expense of someone else, and therefore need not be provided for. Among those at whose expense it is provided is almost certain to be the *doctor* because, of necessity under existing conditions, the hospital, the nurse and the pharmacy have first access to whatever small sum may be available. As a result the doctor operating on the sliding scale, finds his scale has slid to the very bottom, and there is nothing or little left for him.

If the doctor is able to practice among this group for fees of \$2 or \$3, and also attend to surgical and special needs for fees of \$25 and \$50, it is possible that this amount may be available for the medical service which he renders. Under existing circumstances, a large amount of this practice has to be done if

the doctor is to be properly paid and have a sufficient income to meet the requirements of his position.

As a matter of fact, it is known that this is not the case. All the studies have shown that the average doctor throughout the United States is receiving total compensation that is hardly above the grade of a skilled artisan and in many cases below that grade.

HEALTH CATASTROPHE

The second difficulty, and the major one, however, has to do with conditions when a serious *health catastrophe* arises in a given family of this group which we are discussing. So long as only the ordinary illnesses have to be met, it is possible that the budget will stand the strain and the doctor get some return that is worthy of consideration. When, however, the catastrophe occurs, there is absolutely nothing left for the doctor; and for long days, weeks and even months of service or performing of serious operations or services in the field of the specialties, he can receive no return of any kind as every cent is absorbed by the incidental costs of sickness aside from those arising from professional service by medical men.

In addition to this, the family is financially wrecked to meet the other costs, and the meager savings of years may be wiped out in one stroke and the family find itself severely in debt against which a struggle lasting for years has to be undertaken. If the illness attacks the important wage earner of the family, the problem is that much more complicated a project.

We, as doctors, do not need statistical data to prove to us that this situation is not a rare one. Not a year goes by but we personally are acquainted with one or more such incidents and we know that the grand total is very large. It is this situation which is disturbing to the sociologists, the economists, the public minded persons who have accepted as a basic truth that all persons should have good medical care and that the doctors should be properly compensated for rendering this good medical care.

HEALTH INSURANCE

It is this underlying thought that has stimulated the foundations to attack this subject earnestly. And if I read the times correctly, the results of all their studies are leading to the belief that the solution lies in some sort of *health insurance* whereby the individual will be required each year to allocate a certain portion of his budget to meet this situation; and that portion, added to a sufficient number of others doing the same, augmented by a charge upon the employer if there be one, and still further increased by public funds—local, state, and even federal—will set up a grand total of sufficient amount to meet these major catastrophies as well as the minor ordinary illnesses without penalizing the doctor or wrecking the financial standing of anyone.

This, in short, is the insurance plan. Ten thousand persons pay annually \$20, \$25 or \$30 a year. This total amount is placed in a central fund and entitles the individual who has so paid, whether from his own resources or from those of his employer or from the state, to good medical care at all times.

This problem certainly sounds simple, and yet the doctor's first reaction to it seems to be that he will not be a party to any such system because it takes away from him his individual prerogative. It will not permit the patient to choose his own doctor, it will destroy competition and initiative, and it will be the subject of racket.

An analysis of the situation does not seem to make these objections tenable if due consideration is given to them in setting up a properly guarded procedure. Briefly, that procedure is that all persons entering into this system shall have the right to choose their own doctors with the same freedom as if they were to pay the bill out of their own pocket. These persons indicate that they would like Dr. X as their doctor. Dr. X accepts them to a number that is decided upon by the organization, usually 1,000 to 1,500 persons. For each person on his list, he receives a definite annual fee from the central fund. That annual fee has been estimated at from \$5 to \$7. He therefore is a salaried man to that extent.

In return for it, he has to render such service as is needed by his 1,000 to 1,500 clients. His relation with his patient is exactly as it always has been, except that he does not have to send a bill or be concerned with the payment of that bill or put it on a sliding scale.

If the patient does not like the doctor after a trial, he is at perfect liberty to inform the central authorities of that fact and assign himself to another doctor.

Similarly, if the doctor finds that the patient is captious, impossible to satisfy, or demanding unnecessary attention, he is equally at liberty to inform the central authorities that he wants the patient removed from his list.

It is difficult to see wherein the relation between the doctor and the patient under these conditions differs from the relationship that has maintained always insofar as illness is concerned. It differs in no way from the relationship that has existed between all the doctors who serve free hospital services wherein the patient comes to them without any previous relationship between them, and without any choice on the part of either, and without any financial obligation from one to the other.

It is difficult to understand why the doctors have so strongly emphasized the lack of personal relationship in a plan of this sort when they have been so accustomed to treat innumerable patients in the out- and in-services of hospitals under exactly similar conditions and have felt just as responsible and just as close a personal relationship as though that individual had walked into their offices, applied for attention, and placed a \$5 or \$20 bill upon the desk in return therefor.

Competition is not lost in this plan because, since the patients in the group have the privilege of selecting any available doctor within a region of the system, those doctors who render the better service will receive the largest number of persons and thereby be paid the greatest amounts. Those who are negligent, careless, lazy, or indifferent will find their lists depleted and the lists of doctors of best characteristics increasing.

As to what shall be the charge against each beneficiary of this system—whether it shall be

paid in larger or smaller amount by the individual, the employer or the state—what compensation shall be returned to the doctor—what organization shall be set up for the administering of it—are matters which will have to be worked out according to the circumstances of the local situation.

If the doctors will give this matter their serious consideration, recognize what I believe is the inevitable trend toward it, grasp the problem firmly and understandingly and intelligently, there is sufficient data already at hand to make one who has studied it believe that it is practical and able to meet the requirements of the problem we are discussing.

Is there danger of its becoming a racket? Yes, and these dangers come from two sources, one outside of the profession and one within the profession.

The total bill of the United States for Medical Service is estimated at over three billions of dollars. This is an enormous sum of money and is obviously going to attract crooks who are ever on the alert for just such an opportunity. If the medical profession has not sufficient initiative, wisdom, and force to keep this group out, there is danger that a racket will result.

From the inside, the plan would be attacked by those of the profession who have in the past shown themselves just as venal as racketeers without the profession. The failure of the Workmen's Compensation, the care of our veterans, the application of various pension systems having a medical aspect has been in not a little measure because men holding the M.D. degree have prostituted themselves and their profession by resorting to crooked methods. That is a strong statement, but it is born out by the studies of those who investigated the situation in New York State for Governors Roosevelt and Lehman, by those who attacked the iniquity of veterans' compensation, and by those who have investigated other instances where corruption has existed. Somewhere in the circle of viciousness is found a doctor's signature which was necessary and which was unhesitatingly applied. If the medical profession cannot keep the plan

out of the control of such elements, disorder will result.

CONCRETE ADVICE

It is, I believe, beyond my mission to attempt to advise you in Morris County as to how you should proceed to meet your own situation. However, I will venture to make one suggestion, namely, that you should select a small committee, composed of men who will have the time, the interest and the impartiality to study this question as applicable to your own needs. It is my belief that such a study, including a careful evaluation of all the various reports and discussions which have taken place, would result in a concrete plan whereby the problem of the middle economic group, if it exists in Morris County, would be solved. If some studies could be prosecuted by your adjoining counties or possibly by the entire state, it seems to me that, as I said originally, the State of New Jersey has an unusual opportunity to lead the way.

Michigan, California and other states have taken steps with greater or less success. Their plans and results should be studied. The report of the meeting which was held in Philadelphia in April of this year and was published by the American Academy of Political and Social Science under the title "The Medical Profession and the Public" should receive attention. The various studies that have been brought out by the Milbank Fund should receive attention. The supplement of the May 1934 issue of the Journal of the Michigan State Medical Society has a full report of their attempt. From these initial sources there is reference to a very extensive literature which must be considered.

May I say in closing that I do not stand here as an advocate of the plan so briefly outlined, because I have not made a sufficient personal study to convince myself that some other plan may not be a better one. Theoretically, it appeals to me, but if I had the responsibility in Morris County or any other county, I would simply take it under consideration and in connection with that situation use my best endeavor to learn whether some better plan is applicable to the situation as it exists here.

DISPENSARY ABUSES

By LYN W. DEICHLER, Philadelphia, Pa.,

Member Philadelphia County Medical Society Commission on Medical Economics

Read before the meeting of the First and Second Councilor Districts of The Medical Society of New Jersey.
in the Academy of Medicine, Newark, N. J., April 12, 1934.

The Economic Program of the Philadelphia County Medical Society was launched in January, 1933, and is a comprehensive one. At the beginning, it was received somewhat with suspicion and inertia—a sort of “what’s-it-all-about” attitude. We are all so delightfully individualistic, to our own detriment, and much work of an educational nature had to be done. It has been only through the untiring efforts of the various committees and the commission that today we have more members in the Society, paying \$20 a year, than we had when the fee was but \$5, and 1600 of our 2000 members have signed up to support our program on economics. Much has been done, also, to destroy the vampires which were feasting upon our blood and leaving us, as a profession, lifeless and inert. As a profession, we are entering a new era, in which I hope the individual physician will once more enjoy sufficient remuneration for his services that will permit him to enjoy life, liberty and the pursuit of happiness, free from the anxiety and concern which has been so prevalent. If not, then he cannot devote his time to scientific research and preventative medicine, and the progress of our art falters and fails.

May I refresh your memories for a moment, by picturing for you conditions as they were when this movement started: We were engaged as practitioners of the art of medicine, in the third largest business in the world. Our philanthropies were legion. In spite of financial suffering and personal privations, we contributed to charity free medical service, conservatively estimated in the amount of \$12,000,000 annually. Some place the amount as high as \$20,000,000. This is a 100 per cent service, given freely in the spirit of humanity, for which we are permitted to make no deductions of any kind.

During this period, 19 per cent of the doctors in Philadelphia had had incomes of \$1000

or less and were no longer able to make a living in the practice of medicine, and most of these had been in practice for twenty years or longer. This meant that approximately 400 of our members either had to find some way to augment their incomes or give up practice.

One of the most important factors responsible for this decrease in the earnings of the physician was the increasing habit of those who could afford to pay for private medical care of seeking medical attention at free clinics. Yet the dispensary of any hospital is a place for the efficient treatment of only the deserving sick poor, and except for emergencies, none but this class of patient should be admitted. The medical and surgical staffs of our hospitals are composed of men who give their time and talent to the worthy poor, without monetary compensation. Hospital practice had extended this free service to include all kinds of specialized care. Gradually, the hospital became the active competitor of the local practitioner, patients going to the hospital rather than to their neighborhood doctor.

Hospitals were forced to become financially ambitious. Their income from private patients was dwindling; their endowment funds, due to the unsettled prevailing conditions of economic readjustment, were greatly reduced, and their overhead expenses, terrific, because of the programs of expansion in buildings and equipment; they were operated on an inefficient, extravagant scale without due regard to public interests and the interest of the patients and the profession. In their effort for survival, many iniquitous practices were instituted; i. e., compensation cases were solicited from industrial plants and insurance companies, treated for nominal fees, operations performed and the fees collected retained by the hospital; accident wards made feeders for their wards and dispensaries; nominal fees for registration and subsequent treatments were collected; dispen-

sary patients encouraged to leave their family physicians; no supervision of the patients' ability to pay, the really indigent being the only class investigated and the able-to-pay patient encouraged to return; drug and optical departments conducted at a handsome profit, in real exploitation of the public. The extent to which this is done is reflected in the published report of one hospital, which in one year reported a net profit of \$12,229 from its drug department and \$32,179 net profit from its optical department, or a total of \$44,408 from this source alone.

The Boards of our hospitals were interested only in making money—they had no desire to harm the doctors per se, but were doing everything they could to increase revenues. Managers and directors of some of our institutions, having had clinics established, were now unwilling to do anything to limit attendance, and through their obligation to perform routine duties, the staff, under threat or penalty of dismissal, were more or less compelled to treat cases which were not proper cases for the dispensary and ward without personal remuneration. Before long, they found themselves engaged in gratuitous, ruinous competition with their own profession. Both the doctor and the patient were thus exploited to the selfish gain of the hospital. All of us have had patients paying moderate fees—fees within their incomes—weaned away by free dispensary advice and no better treatment. The great hospitals are largely to blame for this, and yet they are the most clamorous for financial relief.

A questionnaire at that time revealed the fact that about 76 per cent of the patients, who habitually attended the out-patient departments of our hospitals and other free agencies and health centers, were able to pay the family physician. Do you wonder that we felt that charity had become a racket and that something had to be done to save the doctor?

An explanation of our financial troubles was demanded and we were told that the economic condition was responsible for our plight, but a careful analysis revealed the fact that dispensary and hospital abuse was even more prevalent during the prosperous years prior to

1929 than it is today. The responsibility, gentlemen, is ours. We must shoulder the blame. The abuses mentioned have existed from the time of the establishment of our first hospital dispensary about 1786, but have grown steadily worse through the years. The staff of every hospital knew they existed. These evils were carelessly accepted without protest and because we were earning a comfortable competence, no real effort was made to control or correct them. We saw dispensary abuse increase, but permitted it to grow until it threatened to destroy us. Part of this tolerant attitude may be explained by the fact that the doctor, because of a humanitarian impulse—the urge to help—has always assumed the burden of the indigent and has unconsciously been "breeding paupers by educating parasites".

While it is the desire of organized medicine to give to the public the very best medical care obtainable, the cost of this care must not fall upon the doctor. The care of the indigent, well or sick, is not our responsibility, but properly belongs to the welfare agencies of the city, state or national government. Provision is made for every item except the compensation of the doctor. It is high time this discrimination ceased. Perhaps the government's attitude in permitting a maximum and a minimum charge for the care of those on Welfare is the answer to this perplexing problem, but let us be externally vigilant lest it lead us into a complete socialistic scheme of medicine, with its attending evils, and for us, disaster.

Evils will exist, however, only so long as the medical body is not united in their correction. In every organization, the weight of organized opinion always surpasses that of individual opinion. The organization represents the combined resources of the individuals composing it. In organization there is strength. Our County and State Societies and the A. M. A. are organized for the common good of the profession, and every doctor of medicine should belong to them.

May I digress for a moment to remind you of the prominent part played by the individual practitioners and their county medical societies in distributing to the public the benefits of preventative medicine. Two weeks ago an epi-

demic of psittacosis (parrot fever) occurred in Pittsburgh, which caused ten recorded deaths and a number of cases of grave illness, contracted from the contaminated feathers of the parrots and parakeets on display in a department store. Dr. Isaac Hope Alexander identified the disease, and with the coöperation of the Allegheny County Medical Society and its Medical Bulletin, notified the members of the Society 48 to 72 hours in advance of any other notification, and called attention of the local department of health to the situation, when measures were promptly taken to eliminate the focus of infection.

The family doctor has always been the key man in all the family needs. He must be free to reach out with pity and understanding to the afflicted. Haven Emerson, Professor of Public Health Administration at Columbia University, said recently, "Public health is but the sum of personal health. The competent general practitioner of medicine is the original health officer; the family and the home, the first and best health center."

It is unlikely that many of our members realize either the extent or the power of the forces that are endeavoring to introduce some form of voluntary or compulsory health insurance as the entering wedge for the complete socialization of medical practice. Our County Medical Society and the societies of our State are unalterably opposed to any form of group or contract practice which tends to exploit or commercialize medical care at the expense of the public.

The care of the public in matters of health, disease and injury is, and should therefore continue to be, under the direction of the medical profession. The most important unit of this relationship is the association of the private physician and individual patient. The integrity of this unit should be the basis and principle of all organized medicine. Therefore, in order to safeguard the community health, it is necessary to protect the rights and interests of the private physician, as well as the public individual whom he serves. Since hospitals, health centers, government bureaus and the like are merely accessory to the private physician, it follows that any form of

competition set up by such organized groups against the private physician is contrary to the public interests.

In passing, I would call your attention to the Life Extension Institute service rendered for our large insurance companies in the form of periodic health examinations, given without cost to the applicant and taking our patients away from our offices. Just one week ago I heard Dr. Chester T. Brown, Medical Director of the Prudential Insurance Company of this city, say in an address in Philadelphia, that his company was practically the only one which limited its longevity service to the laboratory, and when abnormalities were detected, referred the applicant to his own family physician, with a statement of their findings, because they believed this work belonged to and was much better done by the family physician in his own office. Furthermore, any extra-professional plan which has for its aim the economic control of the medical profession is a direct attempt to limit the patient's selection of his physician and is incompatible with the best interests of the community at large.

We, therefore, believe, if and when organization of the profession is necessary, such organization should be instituted by the rank and file of the private physician, since 80 to 90 per cent of medical service is handled by this group. We agree with the report of the Committee on Medical Education, that the profession holds as its primary objective today the improvement of medical service, and that the profession is abundantly able and willing to make all such improvement as may be possible, if for the best interests of the unit, the patient and the physician.

Our Society in the past year has made numerous recommendations to our hospitals, among which are the following:

1. No one should be a member of the staff of any hospital unless he is a member of the County Medical Society. A few of our hospitals already require this.

2. Drug departments should be conducted without profit. Their chief function is to provide adequate supplies for the various departments. It is also the duty of the staff to compile a list of drugs other than proprietary, and

carefully instruct the internes at their hospital to use them. The Committee on Prescribing and Dispensary Practice, of which Dr. Douglas MacFarlan is chairman, has compiled a pamphlet, "A Guide to Inexpensive Ethical Prescribing", containing about 300 prescriptions covering the treatment of ordinary diseases and using only N. F. and U. S. P. preparations. This is in the hands of the printer and a copy will soon be sent to each member of the Society.

In its final analysis, there is no excuse for the maintenance of an optical department in any hospital. Every hospital conducting such a department shows a decided profit from the sale of glasses. The practice is unwise and the public is exploited. I do not believe any hospital would maintain this department if their system of handling glasses were deprived of its profit.

3. The staff of every hospital should have representation on the lay board of the hospital, such member or members to be appointed by the staff itself. The Board would then have a better understanding of the problems of the staff and should coöperate with it. In Philadelphia, staffs are now definitely represented in some way in about two-thirds of the governing boards of our hospitals. This reacts for good when we consider the psychological effect upon the work of the hospital staff, by reason of their control of the medical policies of the hospital. Then again, this act of the Board of permitting the medical problems of their hospital to be supervised by the staff will receive the moral support of the medical profession at large, to the direct financial betterment of the hospital.

Five of our hospitals (Jefferson, Frankford, Women's, Jewish, and Presbyterian) have appointed what is termed an "Economic Committee", consisting of three to five members of the staff. This committee discusses certain phases of medical economics involving the relation of staff members to their governing body, and their contact with patients in the hospital and in the dispensary; have representation on the Board of Managers; power to control the medical policy of the hospital; the right of physicians to charge for certain types of hos-

pital treatment; and considers the abuses as discovered in their hospital. It is planned to have these committees meet together at stated intervals, in order that their mutual problems may be discussed and a solution found for their correction. One of these (Jewish) has perfected an ideal plan of organization, which is functioning 100 per cent.

4. The Bureau of Legal Medicine and Legislation of the A. M. A. rules, "No hospital is operated efficiently or economically if it fails to provide adequate machinery to prevent the diversion of its funds to the service of unworthy patients." It follows that there should always be a sensible investigation to determine the patients' ability to pay. The burden of proof should rest upon the patient. It would help much if no case were admitted to any hospital for free service, unless with a letter from the family physician or a note signed by two responsible lay individuals—the local priest, pastor or rabbi, reputable business men in the community, or the district welfare worker—who can certify that the patient is known to be indigent and without sufficient financial resources to pay for private care. In addition, a patient once registered and discharged cannot return at any future time without a certificate of his present economic condition. I believe that much of our hospital abuse would be corrected if this one measure were universally adopted and conscientiously applied. I am happy to report that seven hospitals in Philadelphia have complied with this requisite and have been placed upon a published Honor Roll (Frankford, Germantown, Misericordia, Philadelphia General, St. Luke's, Temple University, and Women's). To this list we would add two in Delaware County (Delaware County and the FitzGerald-Mercy) just outside the city limits.

We know that in some of these hospitals free ward and dispensary attendance has been reduced from 10 to 15 per cent and, in turn, occupancy of semi-private and private rooms has increased from 5 to 10 per cent. One item alone—the restriction of free insulin—is saving thousands of dollars a year.

If cases are admitted in which there is a suspicion that they are not indigent, they should

be referred to a representative of the staff and their condition determined. The ideal method would be through a competent financial investigator in the employ of the hospital who should, by preference, not be directly associated with the Social Service Department. Any patient thus investigated and found able to pay should be referred back to his family physician. No doctor should be compelled to give free service to any one who is not entitled to it.

Teaching Institutions present conditions peculiarly their own because material must be secured for the students' training, yet even in these institutions flagrant abuses must be corrected. Finally, when free patients are discharged from the hospital, they are encouraged to have any follow-up treatment given by the family doctor.

The city of Philadelphia is being divided into sections and a list of physicians in each section willing to accept these patients at reduced rates is being compiled. When completed, a copy of this list will be given to the Social Service Department of each hospital in order that each patient may be discouraged from returning to the hospital dispensaries for further treatment.

5. The occupation of each dispensary patient should be carefully determined on his admission to the hospital. Careful scrutiny of this detail in one of our hospitals has revealed some surprising information and has been the means of cutting down the attendance to a marked degree.

6. Patients paying full ward rates should be charged a minimum fee by the attending physician for their medical or surgical care. Contracts have been made in times past with the hospitals establishing endowed rooms, which contract included free medical and surgical care. Our courts have handed down the legal decision that these contracts may not be broken. When made, however, the staff was not consulted and never gave their consent as a party to the contract. Hospitals generally have adopted our plan, which recommends that free medical and surgical service may be provided in these cases by the Junior Staff, or the internes of the hospital. If, however, the patient insists upon a member of the Senior Staff

rendering the required service, the doctor may, at his discretion, refuse to give free service, in which case he is permitted to arrange with the patient for the payment of a satisfactory fee for his care.

7. Cases protected by health and accident policies are not indigent and, therefore, should not be treated except in the semi-private wards, where the physician is permitted to charge a minimum fee.

8. Workmen's Compensation, Public Liability and Emergency cases, if ambulatory, should be prohibited from admission to the dispensary or ward of any hospital, except for first aid treatment. They should pay for this treatment at a rate commensurate with the charge for such service, if rendered by the private physician in their locality, and then referred to their family doctor for further care and attention. If, however, the case must be admitted to the hospital, it must be referred to the semi-private or private rooms and the staff member responsible for the case notified. Special study—x-ray, etc.—should be charged for by the doctor making it.

We also believe:

1. The staff of each hospital should unite for their own protection. When an individual has built up a department by his own personality and work, much or which is referred private work, and is removed from service either by dismissal or an offer of a contract reducing his income to the benefit of the hospital, or the appointment of a full-time man to take his place, but who receives a much lower pay, the staff should refuse to support this department. With this lack of support, the Board will soon change its attitude in favor of fair dealing and consideration of the individual staff member, head of the department. In the same way, the hospital brings pressure to bear on its staff to send private laboratory work to their hospital. Here again there is danger of building up a private practice within the walls of an institution, especially on a full-time basis. The institution may then, at will, take control or dispose of it as they please. This situation is to be avoided.

2. The medical profession should have representation on the Board of every welfare

organization and health agency in order that they may actively assist in correcting existing abuses in the distribution of free medical service. These agencies are well able to determine the financial status of the family and to decide whether or not the case is deserving of free care. Every patient that can pay a minimum fee should be referred to the family or neighborhood doctor, with a statement of the amount the patient can pay, and not to the dispensary of any hospital.

3. The public should be informed that doctors are not paid for their services in the wards and dispensaries of the hospitals. Many laymen have the erroneous impression that doctors are well paid for this work, and, therefore, have no hesitancy in demanding free service. We contend that this situation should be corrected and that doctors giving their free service to hospitals must be compensated for this care.

4. Referring children to the dispensaries by either the doctor or any other agency should especially be discouraged. They become dispensary-trained. Later, having grown to mature years, they rear families of their own who inherit this training, and become, in turn, dispensary-minded in ever increasing numbers. Our eye, nose, throat and ear men have agreed to treat, in their offices, all children at a fee, which the Welfare Nurse, after an investigation, certifies the patient can pay. This, in some instances, has been as low as \$3 for a refraction—the glasses furnished for a like amount through the coöperation of our reputable opticians—and tonsillectomies are done for a minimum charge of \$15.

5. A comprehensive course in economics should be added to the curriculum of the senior class of our medical schools. Until this is accomplished, the staff of each hospital should carefully instruct their internes in the essentials of medical economics.

6. If the staff and/or the Board of any hospital is found to be unsympathetic and will

not coöperate with the suggestions of our Commission on Economics as to what is expected of them in order to comply with their recommendations, this fact, together with information of all justifiable complaints of the lack of coöperation, will soon be published by our Society among its members, who in turn will be encouraged to withdraw their support from the offenders. Fewer cases will then be referred and the occupancy of semi-private and private rooms curtailed, reflected in decreasing income to that hospital and its staff.

This suggestion is most effectual, as may be seen from the following incident: The fact that a member of the major staff of one of our largest hospitals was supporting the Foundations in their propaganda for the socialization of medicine was quietly made known. Before long, due to a decided reduction in the cases referred to him, this individual appeared at the County Medical Society and stated he had always been heartily in favor of its Economic Program and hoped they would correct the impression that he was unsympathetic. A few weeks later, however, this same gentleman advised the head of a second hospital, with which he is connected, not to appoint an Economic Committee but to ignore it. It is high time that those not in sympathy be brought into the open and the true facts made known.

In closing, may I call your attention to the fact that union methods have won a place for labor. With such widespread hospital abuse,—the formidable attempts to socialize medicine by lay groups and foundations,—the increasing exploitation of the medical profession through the medium of our papers, magazines, billboards and radio, which compel us to compete with those who offer free advice regarding medical treatment,—the appalling growth of cults and quacks,—we, as individuals, are threatened with disaster. If the doctor is to survive, union methods must soon be employed by the medical profession. United, we stand—divided, gentlemen, we fall!

ARE WE HEADING FOR THE LAST ROUND-UP?

By FRANCIS F. BORZELL, M.D., Philadelphia, Pa.,

Member Philadelphia County Medical Society Commission on Medical Economics

Read before the meeting of the First and Second Councilor Districts of The Medical Society of New Jersey, in the Academy of Medicine, Newark, N. J., April 12, 1934.

That physicians of America are approaching a crisis in their affairs with appalling rapidity brooks no denial. Is this crisis to be the "Last Round-Up" of professional independence, economic security or ethical integrity?

The answer to this question can only be found in a full understanding of the problem confronting us. Shall we be stampeded like a vast herd of cattle on a chartless prairie toward the confines of the corral of socialized or state medicine, to be forever limited by the fences of political greed, misguided personal ambition; fences that are decorated by the thorny roses of doubtful philanthropy planted there by the stealthy hands of foundations spending millions of wealth accumulated under an economic system that because of the dry rot of selfishness and avarice finally crashed about our heads in the dark days of '29?

This may be a dark picture; the ominous clouds of professional oblivion are perhaps threatening, but is there no hope? I believe there is. Our salvation lies not in the dubious plans presented to us by those interests responsible for the majority report on the Costs of Medical Care, nor can we hope for relief at the hands of impractical economic theorists expounding words of wisdom from the sheltered swivel-chairs of subsidized college professorships, whose wisdom is borne of charts, graphs, surveys, etc., drawn as a red herring across our path under the guise of profound scientific research.

May I be pardoned in drawing a simile from Holy Writ? The Great Physician was taunted by the cry, "He saved others, Himself, He cannot save." Have we not been taunted and harassed by similar cries from within our own ranks? How often do we hear, "You cannot save yourself. Be content, accept the inevit-

able. State medicine, health insurance is coming. It cannot be stopped."

In a few words, *we must save ourselves*. We must be as we always have been—defenders of those high standards of medical service enunciated over 2,000 years ago by Hippocrates. Our defense is not selfish, it is not mercenary as our opponents would imply. We are attempting to hold inviolate those principles that have proven to insure a maximum of progress, a solidarity of ethical integrity resulting in a standard of service not paralleled in any other field of human endeavor. No system of government, religion, or philosophy has withstood the vicissitudes of time as have the ethics of our profession. Therein lies the bulwark of our strength. The crucial test of ages have failed to break down the foundation upon which we have builded.

So much for rhetoric. After all, words alone will not suffice.

To successfully combat any foe, whether it be social, economic or scientific, we must apply the time honored methods of diagnosis—etiologic and pathologic—and treatment. But before applying these measures we must have a patient. Strangely enough, we are actually dealing with two patients—the public and the doctor.

Let us ask ourselves a few questions. Is medical service (the doctor) actually sick? Economically—yes, basically—no. We all know the tremendous strides medicine has made in the short lifetime of most of us. No honest criticism can rest upon our achievements and volume of service.

Economically we are sick. In our zeal for service, and harboring a false sense of security in the belief that the world is actuated by the same ideals as we all have been, we have failed to note the insidious encroachments from all sides on our domain. I need but mention a few, such as dispensary charity abuse; hos-

pitalization abuses; governmental encroachments for political purposes such as free services to municipal, state and national employees, politicians, satellites and parasites; free clinics and foundations of all sorts under the guise of public charity, etc., etc., ad nauseum. It is estimated that over a billion dollars have been invested in funds and foundations. One naturally questions whether the popular game of "hide and go seek" with income taxes may not have been played in the development of these vast funds.

Let us consider for a moment the other patient—the public. It is quite obvious that the public is sick, economically and socially. A discussion of the present state of society and the causes for our present conditions is not within my province, let alone my capabilities. Nevertheless, the basic causes of our present economic situation are of course reflected in our own profession, but any attempt to isolate medical service from the whole and claim that we are responsible for the inability of thousands to provide medical service for themselves is unjust and wholly unfair.

Mr. Edgar Sydenstricker, Director of Research of the Milbank Memorial Fund and Statistician United States Public Health Service, recently presented a paper at Philadelphia entitled, "Medical Practice and Public Needs." Under the heading of "Public Need of Medical Care" he said, "Medical care is necessary for the maintenance of the health of the people and should be provided to all who need it." We would substitute, and should be *available* to all who need it. By the same token, good housing and warm clothing, ample food and leisure are all necessary for the maintenance of the health of the people and should be available for all who need them.

Mr. Sydenstricker added, "A proper corollary is that any system of medical practice must be judged by the extent to which good medical care is afforded to all who need it." In this we see an attempt on the part of the layman to place the financial responsibility for the distribution of medical service at the doors of the medical profession. Are we

responsible for the existence of the indigent? On what hypothesis or system of social or economic justice can such implications be based? They say the citizen has a right to enjoy health and that the welfare of the state demands medical service for all. By the same token, what is more essential to public health than ample food, clothing or shelter? Then why, in the name of justice, do they not say as a further corollary—any social, commercial or industrial system must be judged by the extent to which the necessities of life are afforded to all who need them?

We do not deny, but rather emphasize, that the state has a responsibility to its unfortunate, its indigent, but why less so in matters of medical care than in other essentials of life. For the first time in history, the present code of the F. E. R. A. recognized the right of the physician to be paid for services to the indigent. True, there may be in this very recognition the insidious beginnings of greater demands for the extension of some system of socialized medicine. Let it, however, be constantly borne in mind that this is an emergency and we cannot allow it to be used as a stepping stone to permanent policies.

Thus we see that the medical profession is beset on all sides by forces which are tending to take from us the control of things medical and place them in hands of non-medical agencies; a condition which can only result in a lowering of our standard of ethics and service. We have a commodity in medicine that cannot be measured by the usual standards of industrial economics.

Webster defines economics as "The service that investigates the conditions and laws affecting the production, distribution, and consumption of wealth or the material means of satisfying human desires."

Medical economics, therefore, deals with the conditions and laws affecting the production, distribution and consumption of medical services or the means of satisfying human health desires.

A proper and equitable economic status implies a fair return for value received. The principle of "quid pro quo" is so basic that any economic system or usage demands that

the "quid" equal or approximate the "quo", and it is an established fact of history that when this balance of values is disturbed, there automatically ensues a leveling process. In other words, if the returns are not sufficient to maintain a given high standard of quality or efficiency, the returns must either be enlarged, or the quality and efficiency sink to the level of the returns. It is at this point that every effort made to parallel the principles involved in industrial economics and those of medical economics "comes a cropper". Any attempt to apply the principles involved in industrial economics to those of medical economics fails because of one thing and that is that the commodity or the "quid", namely—medical service, cannot be raised or lowered in quality dependent on the "quo" received. However, the law still remains, and if it should so happen that the present tendencies in certain directions should persist, aiming at the so-called socialization of medicine, then the result will inevitably be the lowering of the quality and efficiency of medical service.

Quotation from "An Introduction to Medical Economics".

"It is of importance also to note that one of the most distinctive characteristics of services is that, not being material commodities, and being inseparable from the producer, they never enter the market place in any such sense as do wheat, iron, shoes, coal and other commodities. Hence it seems fair to conclude that any theory that looks to such a market to establish values must fail to account for the value of services."

Modern medicine, however, has by rapid evolution become so intricate and involves every phase of our social structure, that the problems of the individual physician have become equally involved and cannot be solved without careful consideration of a large number of intimately related questions.

Let us first tabulate some of the factors involved in the medical structure of our country. These may be divided into three component parts of our definition of economics, namely:

- Production
- Distribution
- Consumption.

1. Production or source.

The source is, of course, the physician and the physician only. The physician is the product of medical education. Medical education is the physician's capital. That capital is not only the basic \$15,000 that has been invested in his preliminary training but is continuously augmented by the accumulated experience of practice. His capital can, therefore, not be measured in just dollars and cents.

Quotation from "An Introduction to Medical Economics".

"The physician's investment in education and training is a vital part of his life. Its attainment and possession afford him satisfactions entirely apart from its income-producing qualities. He cannot buy or sell it in any market apart from himself. If it is outgrown or rendered 'obsolescent,' he cannot rid himself of it by 'writing it off' some balance sheet. Because it cannot be used by anyone else it lacks the characteristic quality of industrial capital—it cannot compel the labor of others.

"His office and his professional equipment partake of this same personal character and are of little value when separated from his personality. His real income-producing possessions are his own knowledge, his skill and his other personal attributes. Overlooking this fact not only confuses the questions at issue but renders nearly all the problems of medical economics impossible of logical treatment and solution."

2. Distribution.

Again the physician is the agent of distribution. Under this head may be included the various auxiliary agencies whose only function should be to assist in the more efficient distribution by the physician. This includes:

- Hospitals with their clinics
- Health Agencies
 - Health departments
 - Welfare organizations, etc.
- Industrial Agencies
 - Compensation measures, etc.

Quotation from "A. I. to M. E."

"All the buildings and equipment, as well as the personnel accumulated and organized

around these are supplemental to and dependent on the immaterial accumulation of knowledge by individuals and the professions. Ownership of this equipment does not give any right to control the application of that knowledge. On the contrary, every attempt to use such ownership for control reduces the value of that knowledge and ultimately destroys the 'capital' itself.

"Yet the existence of these large investments is constantly used as an argument for lay participation in the management of medical service. When this argument is analyzed it is always found to rest, in some way, on a stated or unconscious analogy with industrial capital. Since this comparison is wholly unjustified, it follows that any argument resting on it is equally untenable."

3. Consumption.

Here we must of necessity take cognizance of what appears to be two functions of medicine that cannot be treated in the same manner. They are:

1. What may truly be termed social medicine. Namely, public health measures, including sanitation; various preventive measures, both disease and accident, and social hygiene.

2. The treatment of specific disturbances or the individual patient.

The first group consists of public health measures which demand mass activity and call into play engineering, political economy, social welfare activities and civic health agencies. Although these activities require lay workers with special training and equipment, the need for these activities is always originated and directed by the medical profession. This medical source is again a part of what has been called the "social capital" of medicine.

May I again quote from "A. I. to M. E."?

"The real 'Social capital' of medicine is the steadily growing body of knowledge rather than the increasing value of the investment in hospitals, clinics or laboratories. This 'capital' is stored in the publications, minds and traditions of the profession and is transmitted through universities, journals and clinics to the individual physician. The profession itself is the owner and custodian of this vast mass of invaluable wealth. It cannot be in-

dividually monopolized for profit. * * * Separated from this body of knowledge, the physical 'capital' is worthless."

It might be said, and has been said, that our concern is only with the second group, namely—the treatment of specific disturbances or the individual patient. This would be true if the activities of the first group remained purely general. The moment they involve the diagnosis and treatment of the individual they become matters for the economic consideration of the physician.

It therefore follows that, for our present purposes, consumption deals with the individual or the patient. That is, there is no such thing as wholesale consumption of medical services. This means, therefore, that the recipient of these services (the consumer) is an individual and forms the basis for the contention that one great basic principle to be maintained is the opportunity for individual choice of a physician. Any system which destroys this principle tends to decrease the efficiency of medical practice.

Ample statistics are already available to show the really meager or inadequate income of the profession and the progressive attenuation it has suffered for some years past, even ante-dating our present depression. Therefore, any study of the costs of medical care must be directed to sources other than the physician's income.

A casual glance at the following table amply proves our contention that the public is not paying too much for medical care.

I.		
Total Family Population in U. S. 30,000,000	Cost Per Family Per Year \$150.00	Total Paid Cost \$4,500,000,000
II.		
Luxuries in U. S.	Cost to Produce	
Automobiles	\$5,260,723,000	
Gasoline	2,639,665,000	
Tobacco, Chewing Gum	1,163,768,000	
Motion Pictures	180,864,000	
Confectionery	388,708,000	
Radio	439,961,000	
Total	\$10,073,689,000	

Annual production cost of luxuries for the American family	\$336
Retail Cost	672

III.

Physician Population in U. S.	Benevolent Medicine Per Physician Annually	Total
\$140,000	\$4,500.00	\$630,000,000

But what does our previously mentioned friend, Syndenstricker, say about it?

"There is being spent annually by the American people enough money—about three and a half billion dollars—for doctors, nurses, medicines, and all sorts of medical services, good and bad, to purchase reasonably adequate medical care at current average prices." According to his statement, "Less than seven percent of the population" has been receiving adequate medical care, which statement we do not at all concede; then logically the further medical services that would be necessary for the additional ninety-three per cent should be provided but at no increase in cost to the public.

Every effort, so far, made to reduce costs of medical care has been directed towards the reduction of the expenses represented by the physician's services. Insurance companies, hospitals (controlled by lay boards), welfare organizations, compensation laws, health department activities, all have steadily and in increasing degree encroached on the physician's income. To enumerate these encroachments in detail would serve no purpose in this discussion. Thus far this argument has dealt in generalities, but the solution of these problems are reached only by detailed consideration of the problems as met in every day practice.

Just a few words concerning the tendency in some sections of our country toward health insurance, both compulsory and voluntary. The present flood of various health insurance schemes seems to have started with the impetus given by the Report of the Committee on the Costs of Medical Care.

The west coast has been quoted at some length by Michael Davis, of the Julius Rosenwald Fund, as an example of the forward looking policies of certain groups of our profession, with a view to discredit the stand of the American Medical Association and such local groups as the Philadelphia County Medical Society. But, as is often the case with paid propagandists, the truth is not in them. The

group plans promulgated by certain County Medical Societies in Washington and Oregon were organized as a defensive measure against the prevailing wholesale contract practice schemes made possible because of the peculiarity of their compensation laws.

Permit me to quote from a letter received from Dr. R. G. Leland, of the Bureau of Economics of the American Medical Association, in answer to our queries concerning the west coast situation.

"Were I to give you the complete picture of conditions on the Pacific Coast, it would require almost a book in size. Perhaps the most striking departure is that found in the State of Washington, where practically the entire state has been organized to care for illnesses among the industrial employees through the agencies of medical service bureaus incorporated and operated by county or district medical societies. Some of the objects for which these organizations were formed were:

"1. To spread the volume of industrial work more evenly among the members of the county medical societies.

"2. To control or eliminate the established type of contract practice which for so many years had been operated by a few individuals and groups.

"3. To prepare some form of organization which might be utilized perhaps with some modifications in case health insurance became legalized and compulsory in that state.

"In seeking to correct the undesirable and dangerous features of the whole contract system, medical societies through their new organizations, the medical service bureaus, found it necessary to use the same methods and tactics that had been developed by those whom they now sought to put out of business. For example, solicitation of business was necessary. Under-bidding was resorted to when necessary to get contracts; benefits were not confined to the low income industrial worker, but in order to secure contracts, the owner, superintendent, or general manager was also included. In addition to the above, new fields of contract or insurance practice were opened among the employees of organizations which had never considered it necessary to use this type of medi-

cal care. It should be noted that only approximately 50 per cent of the physician members of the medical service bureaus were supporters of this plan at the time I made an investigation in October, 1933.

"In Oregon, a state law provides for the registration and reporting of hospital associations. A number of such associations have been in existence in that state, particularly in Portland, for many years. In the last few years, associations of a similar nature have been developed by the members of county medical societies. The function, organization, and methods of operation, as well as the contract coverage are similar to those of the medical service bureaus in Washington. The extent of this type of organization in Oregon is considerably less than in Washington.

"In California, until recently, there have been at various times in the neighborhood of from 100 to 150 medical service organizations existing under all sorts of names, organized by individuals or groups to give medical service at small monthly sums. There has been a very great amount of shifting of names and consolidation of concerns, so that the history of the organizations and individuals engaged in this work has been very complicated and difficult to trace.

"Recently it has been found that a number of these organizations have been engaged in somewhat shady practices, and nineteen individuals were indicted on various counts for questionable activities in offering health services to the public."

That is the situation on the West Coast.

We are opposed to group health insurance for the following reasons:

1. On the authority of old line insurance experts it is economically unsound.

2. It tends to definitely lower medical standards because :

- a. It injects a third person for profit.
- b. It excites competition on a financial basis.
- c. The physician becomes a mere instru-

ment in a commercial transaction and is consequently exploited.

In conclusion, I have attempted to sketch roughly the economic situation of the practice of medicine in a few of its many phases. Our fight must be directed toward the maintenance of the highest standards of medical practice by insisting on:

1. The continued untrammelled patient-physician relationship.

2. The complete elimination of any third person in medical practice.

3. Complete organization not only to defend our own interests but to insure for the patient the best we can give them.

The future of medicine; the maintenance of its ideals long cherished; the continuance of lofty professional standards; and the insurance of a sound, self-respecting economic existence for those who shall follow us; all these demand that we hold fast to that which is good, fight for the restoration of our rightful heritage, shake off the shackles of industrial slavery and misguided philanthropy often fostered by motives of self-seeking social prestige or the selfish interests of highly paid social workers and executive secretaries. This can only be accomplished by organized medicine.

Our cause is just; our motives are pure and truly unselfish. With an awakened conscience assisted probably by the hallowing influences of financial distress, conscious of our own strength, for the remedy lies largely with us, we can stem the ever-rising tide that tends to sweep us toward the abyss of socialized medicine, comparable to the dole and panel of Germany and England.

This organization must be perfected from the ground up. The final details, the specific remedies, must be applied by each local group, thoroughly organized, and lead by those who are level-headed and willing to spend literally hours and hours of valuable time and whose only reward shall be the satisfaction springing from the consciousness of a noble task well performed.

STATE SOCIETY ACTIVITIES

REDUCING C. W. A. MEDICAL FEES

The arbitrary action of the Federal officials in charge of the Civil Works Administration in Washington, D. C., in reducing medical bills 25 per cent, has impelled the Chairman of the

Medical Advisory Committee of the Medical Society of New Jersey to the New Jersey Emergency Relief Administration, to write the following letter of protest.

August 31, 1934

U. S. Employees' Compensation Commission
Office of the Chief of Accounts
Washington, D. C.

I herewith return check No. 54824 drawn for \$13.75 because it does not settle the voucher for \$19.00 submitted by me for payment.

As this is a specific example of your general attitude of arbitrarily reducing medical payments about 25 per cent for Civil Works Administration Compensation work in New Jersey, I hereby formally protest as an individual and as the Chairman of the Medical Society of New Jersey, in behalf of the doctors of New Jersey.

My reasons are as follows:

1. Regulations of the U. S. Employees' Compensation Commission under Federal Compensation Act of September 7, 1916, revised June 26, 1929, page 6, states, "In selecting his physician the injured employee shall inform him that the Employees' Compensation Commission will pay all reasonable charges, but that settlement will be based on the rates fixed or prevailing in the locality for persons receiving the average income of the United States civil employees."

Quotation from Mr. Colt's (State Director of E. R. A.) telegram of November 23, 1933, to County Directors: "All employees of the Civil Works Administration who suffer injuries while in the performance of duty will be paid compensation during disability and provided with medical attention under the conditions prescribed in the Federal Compensation Law of September 7, 1916, and in accordance with the rules and regulations of the United States Employees' Compensation Commission. * * *"

2. Under our mutual agreement with the E. R. A. all the compensation bills for C. W. A. cases in the State of New Jersey were reviewed by the County Medical Committees and passed as fair and reasonable.

3. Under our mutual agreement with the E. R. A. changes in the bills submitted should

not have been made except by joint consideration with our Medical Advisory Committees.

4. The memorandum accompanying the check forwarded to me contains statements absolutely contrary to our mutually agreed upon procedure. I quote:

U. S. EMPLOYEE'S COMPENSATION COMMITTEE

"The Commission is allowing your voucher rendered in this case at a lower rate than that charged by you. It is realized the fees allowed in this case may be lower than the usual fees charged to the average private patient. However, it must be borne in mind that the setting up of the Civil Works Administration program with the allowance of compensation benefits will to some extent relieve the medical profession of the burden of free treatment. In view of the Federal employment of these people as a relief measure, it is not believed the average fees generally charged in each locality are warranted. You will probably find the fees allowed in this case are not less than the fees you charge a private patient in the same income class as the injured employee or the minimum fee schedule of your County Medical Society. They can be compared favorably with fees allowed for medical treatment of the unemployed under authority of the Federal Emergency Relief Administration."

5. The general adoption of this 25 per cent reduction means not only a loss of many thousands of dollars to the physicians of New Jersey for work performed, but it definitely and significantly means the destruction of confidence in any medical plans promulgated by the U. S. Government in place of our previous hearty coöperation.

I trust you will give this matter serious consideration and advise me of your action.

Yours very truly,

SPENCER T. SNEDECOR, M.D.,

Chairman, Medical Advisory Committee.

The principles underlying the cuts in the doctors' bills are discussed editorially on page 502.—Editor.

THE NEW PRESCHOOL RECORD CARD

The Public Health Committee of The Medical Society of New Jersey has prepared a new physical examination record card intended to provide essential information concerning the health and fitness of children *before* they reach the age for entering school. The Medical Society expects that the State Department of Education will endorse and support this plan, as the State Department of Health has already done in its Monthly Bulletin of September, 1934.

If all parents will see that their children are examined by their own physician each year during those most important years of development, and will have any correctable defects attended to by their family physician, much of the large cost for medical inspection now carried by the public schools can be saved. It is better to *prepare* than to *repair* the school child, and much valuable time will be saved for education. Children can also be immunized against diphtheria and smallpox in the "Public Health Hour", and at the age when illness and death from diphtheria is highest.

According to the vital statistics in the New Jersey Department of Health, the death rate from diphtheria has been slightly higher in New Jersey during the five-year period, 1929-1933, than it was in the five years preceding, 1924-1928. Physicians cannot afford to permit this record to continue, since it is in their power to reduce it.

The family physicians in this State must urge upon the parents the need for early protection of their children, and show them the wisdom and economy of having all children enter school fit and ready to get the most benefit from the education opportunity offered in the schools. If the physicians will give *written* instructions to the parents, the results will be increased because the parents will understand better and cooperate more effectively.

The preschool record now available at the Executive Offices of The Medical Society of New Jersey, 137 East State Street, Trenton, should be kept faithfully by each family physician so that it will be available when the child enters the kindergarten or first grade. This procedure would save much valuable time and money to the parents and to the schools.

The practice of medicine in the future will include more and more of important health protective services, especially to the young child. The members of The Medical Society of New Jersey are already showing the way

of health protection and conservatism to other states as is shown by the invitation of the American Medical Association to the Medical Society of New Jersey to have a representative come to Chicago in September to talk before the Annual Conference of Secretaries and Editors of all the State Medical Societies of the United States about the New Jersey program and plans, the success of which depends upon the "everlasting teamwork of every blooming soul", to whom the credit really belongs.

HOW TO USE THE PRESCHOOL CHILD HEALTH RECORD CARD

The record form is so simple that any physician can use it with advantage.

One side of the record card contains spaces for important data regarding the prenatal history, growth and development, communicable diseases, and immunization of the individual child. It also has a space for the examining physician's specific recommendations to the parents; and it carries the name and address of the doctor for the parents' benefit.

On the opposite side of the card are spaces for the important physical and mental examination findings from year to year. These are helpful to the examining physician and to the school inspector, who can more quickly detect departures from normal and urge further observation by the family physician in such cases.

The Parent-Teachers Associations can be most helpful in urging parents to see that such a record is kept of each preschool child; and that this record is taken to the school when the child enters it for the first time.

The cards may be obtained by any physician *at cost*, through the County Medical Societies (Secretaries) and the Executive Office of the Medical Society of New Jersey, 137 East State Street, Trenton, New Jersey.

The present cost is one cent each, plus necessary postage to mail the required number.

LEROY A. WILKES,
Executive Secretary.

The record card is reproduced on the two following pages from the same type that was used in printing the cards. Its great advantage is that it provides a uniform system of recording essential facts which any physician can readily grasp and interpret because he has made out similar cards. —Editor.

	1st Year	2nd Year	3rd Year	4th Year	5th Year
Date					
Weight					
Pallor					
Nutrition (1)					
Bony Development					
Muscle Development					
Nose					
Throat					
Cerv. Lymph Nodes					
Teeth					
Eyes					
Ears					
Heart					
Lungs					
Abdomen					
Other Findings (2)					
Illnesses Since Last Visit					
Habits (3)					

MENTAL DEVELOPMENT (Use Check V)

	1. Walks (mo.)	1. Draws circle from copy	1. Draws cross from copy	1. Draws triangle from copy
1. Stands, may attempt to walk				
2. Understands simple command		2. Combines 2 parts cut puzzle	2. Repeats sentences of 10 or 12 syllables	2. Compares 2 weights
3. Imitates simple act on command	3. Asks for things by name	3. Names 2 objects in a picture	3. Buttons clothes	3. Laces shoes
4. Holds cup to drink from	4. Folds paper imitatively	4. Points to eyes, nose & mouth	4. Washes self	4. Puts on hat and coat unaided
5. Uses 1 or 2 words besides mama & dada	5. Bladder control established	5. Repeats 2 digits	5. Knows his sex	5. Counts 4 pennies

CODE. (1), Excellent, good, fair, poor. (2), Indicate special features. (3), Such as eating, sleeping, bowel regularity, spasms, persistent crying, fussing about food, nail biting, thumb sucking, etc.

CHART 2
Physician's Record Card for the Preschool Child. Reverse Side, for Progress Notes.

GRADUATE MEDICAL EDUCATION

By HARRY H. SATCHWELL, M.D.,

Chairman, Committee on Hospitals and Medical Education

The Committee on Hospitals and Medical Education is about to start its sixth year of activities. It feels that the lecture courses which have been given each year in the past should be continued, but that clinical courses should also be instituted during the coming year. The New Jersey State Medical Society, through its affiliation with the universities in New York and Philadelphia, will be able to offer courses of this character from time to time; these courses to be given at the various university teaching centers. In some instances the courses announced will be chosen from the curricula of the several universities, and will be selected for their adaptability to the needs of the medical men of this State. Some courses, which will be announced from time to time, will be especially arranged for your Society.

The first courses to be announced are as follows:

COLUMBIA UNIVERSITY IN THE CITY OF NEW YORK, UNIVERSITY EXTENSION

Neurology and Psychiatry

The *College of Physicians and Surgeons*, coöperating with the *Neurological Institute of New York* and the *New York State Psychiatric Institute and Hospital*, will offer graduate courses in Neurology and Psychiatry from October 1 to December 7, 1934, either on full-time or part time basis. The staffs of the three institutions will collaborate in courses which emphasize the clinical aspects of these specialties, as well as laboratory and public health phases. Clinical material will be derived, in addition, from the Out-Patient Department of the Vanderbilt Clinic and Montefiore Hospital. For further information address the Dean,

College of Physicians and Surgeons, 630 West 168th Street, New York City.

COLUMBIA UNIVERSITY, NEW YORK POST-GRADUATE MEDICAL SCHOOL

Pediatrics

Under the direction of Dr. Roger H. Dennett, Professor of Pediatrics. Nine Wednesdays from October 3 through November 28, 1934.

This course is designed to meet the needs of physicians residing within commuting distance of New York City, without materially interfering with their practices. Sessions are held from 9 a. m. to 5 p. m. every Wednesday beginning with October 3rd. Lectures will cover: Common Skin Diseases, Surgery in Children, Orthopedics in Pediatric Practice, Diabetes, Trauma in Children, besides many lectures on the Fundamentals of Pediatrics. Ample clinical cases are available for demonstration.

The fee for the entire course is \$35.00.

Address: The Director, New York Post-Graduate Medical School, 303 East 20th Street, New York City; or Dr. H. H. Satchwell, 640 Stuyvesant Avenue, Irvington, N. J.

The Department of Pediatrics also offers an intensive seminar of one month, during the months of October, January, April and July; fee, \$150. During months when the seminar is not in session a clinical course is available including work in the out-patient department and rounds in the Babies' Wards. Fee, \$100 for one month.

Detailed schedules of these courses may be obtained by addressing *The Director*.

NATIONAL MEETINGS OF INTEREST

Two national medical assemblies of special interest to physicians of New Jersey will be held during the Autumn.

THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTO-LARYNGOLOGY

The American Academy of Ophthalmology and Oto-Laryngology will hold its 39th annual session in Chicago on September 9-14, 1934. The Academy has truly been called a traveling University. Each year doctors from all over the world are given the advantage of one week

of intensive study in that branch of the specialty in which they are interested. There are 77 courses to be given this year.

A specific appeal of this meeting to the physicians of New Jersey is the fact that its President-elect, who takes over the Presidency at the close of the meeting, is Dr. Wells P. Eagleton, of Newark, Past President of The Medical Society of New Jersey, and now Chairman of its Board of Trustees. Dr. Eagleton has taken an active part in the courses of instruction of the Academy for some years. This

year he will contribute a paper on "Exophthalmos from Lesions of the Nasal and Cranial Cavities" during a symposium on exophthalmia.

During the session, Dr. Eagleton is to give a ten-minute broadcast on "The Scope and Functions of the Academy", showing its method of choosing members from men certified by the Boards of Ophthalmology or Otolaryngology; its conduct of 70 or more special post graduate courses by recognized experts; its support of research in the specialties; its support of the Surgeon General's great medical library and pathological museum; and its constant effort to keep the membership and profession generally abreast of the latest discoveries in their special field.

POST GRADUATE ASSEMBLY

The Annual Interstate Post Graduate Medical Association of North America will be held in The Public Auditorium, Philadelphia, Pa.,

beginning Monday, November 5, 1934, and extending through Friday, the ninth. Addresses, clinics and exhibits will be the prominent features of the meeting. An intermission is provided in the middle of each half day for a review of the exhibits.

Seventy-five clinics and addresses are scheduled for the week. Each day's work begins at eight o'clock in the morning and ends after ten in the evening. No section meetings are held, but all the members will assemble in one room, as has been the custom in former years.

The subjects of the program are predominantly medical—an unusual feature in a meeting of a great society. The speakers will come from every section of the United States, their names being announced on advertising page XI of this Journal.

To physicians of New Jersey the meeting offers an exceptional opportunity in graduate education along lines which will appeal to the general practitioner.

A. M. A. CONFERENCE OF SECRETARIES AND EDITORS

The annual conference of the Secretaries and Editors of the State Medical Societies, which is conducted by the American Medical Association, will be held on Friday and Saturday, September 21 and 22, 1934, in the Palmer House, Chicago. The A. M. A. pays the expenses of the Editors and Secretaries, and also of the guest speakers.

Dr. LeRoy A. Wilkes, Executive Secretary of The Medical Society of New Jersey, has been invited to address the conference on the subject "The Medical Society of New Jersey Experiments in Furnishing Medical Services in the Community".

Other speakers are:

Dr. Walter L. Biering, President of the American Medical Association.

Dr. James S. McLester, President-Elect of the A. M. A.

Dr. R. L. Sensewich, of the Committee on Legislative Activities of the A. M. A.

Dr. R. G. Leland, Director of the Bureau of Economics of the A. M. A.

Dr. Oliver J. Fay, Chairman of the Board of Trustees of the Iowa State Medical Society, on "The Centralization and Departmentalization of State Medical Society Activities".

Hohman Taylor, Secretary of the State Medical Association of Texas, on "Medical Emergency Relief".

Dr. W. Edwin Bird, Editor, Delaware State Medical Journal, on "Some Problems of a State Medical Editor".

Dr. Clyde L. Cummer, President, Ohio State Medical Association, on "The Educational Possibilities of Scientific Programs at State and County Meetings".

CAMDEN COUNTY

Vincent Del Duca, M.D., Reporter

A Special Meeting of the *Camden County Medical Society* was held August 14, 1934, Dr. T. B. Lee presiding, for the purpose of acting upon the fee schedule as set up by the State Society committee in order to comply with the Physicians' Lien Act.

After having heard the fee schedule read, Dr. Hyman Goldstein moved that the schedule be adopted in toto. This was seconded by Dr. Rogers.

Discussion was opened by Dr. T. K. Lewis, who was followed by Drs. Lee, Rogers, Gamon, Ralph

Hollinshead (by invitation) and Dr. Hyman I. Goldstein. The question was put and was unanimously adopted, that the fee schedule, as stated, be accepted by this County Society.

Mr. W. W. Logan, Acting Director of the E. R. A. in Camden County, explained the attitude of the Relief Administration and his desire to be liberal and fair with the physicians.

The President reappointed Dr. Lewis, Chairman, and the other members of his committee to act for another year as the Local Advisory Committee to the E. R. A.

DATES OF COUNTY SOCIETY MEETINGS

September 1934—July 1935

SEPTEMBER, 1934		FEBRUARY	
11 Bergen	19 Middlesex	5 Camden	13 Union
11 Sussex	20 Morris	7 Hudson	14 Essex
12 Burlington	20 Gloucester	8 Atlantic	14 Passaic
13 Passaic		12 Bergen	14 Somerset
		13 Mercer	20 Middlesex
		13 Ocean	21 Gloucester
		13 Salem	27 Monmouth
OCTOBER		MARCH	
2 Cape May	11 Essex	5 Camden	13 Burlington
2 Camden	11 Passaic	7 Hudson	14 Essex
4 Hudson	11 Somerset	8 Atlantic	14 Passaic
9 Bergen	12 Atlantic	12 Bergen	20 Middlesex
9 Cumberland	16 Warren	12 Sussex	21 Gloucester
10 Mercer	17 Middlesex	13 Mercer	21 Morris
10 Ocean	18 Gloucester	13 Ocean	27 Monmouth
10 Salem	23 Hunterdon		
10 Union	24 Monmouth		
NOVEMBER		APRIL	
1 Hudson	14 Mercer	2 Camden	11 Passaic
6 Camden	14 Ocean	4 Hudson	11 Somerset
8 Essex	14 Burlington	9 Cumberland	12 Atlantic
8 Passaic	15 Gloucester	9 Bergen	16 Warren
9 Atlantic	21 Middlesex	10 Mercer	17 Middlesex
13 Bergen	28 Monmouth	10 Ocean	18 Gloucester
13 Sussex		10 Salem	23 Hunterdon
		10 Union	24 Monmouth
		11 Essex	
DECEMBER		MAY	
4 Camden	13 Passaic	2 Hudson	9 Passaic
6 Hudson	13 Somerset	7 Camden	10 Atlantic
11 Bergen	14 Atlantic	7 Cape May	14 Bergen
12 Mercer	19 Middlesex	8 Mercer	14 Sussex
12 Salem	20 Gloucester	8 Ocean	15 Middlesex
12 Ocean	20 Morris	8 Burlington	16 Gloucester
12 Union	26 Monmouth	9 Essex	22 Monmouth
13 Essex			
JANUARY, 1935		JUNE	
1 Camden	10 Essex	11 Bergen	19 Middlesex
3 Hudson	10 Passaic	12 Mercer	20 Morris
8 Bergen	11 Atlantic	13 Somerset	26 Monmouth
8 Cumberland	15 Warren		
8 Sussex	16 Middlesex		
9 Burlington	17 Gloucester		
9 Mercer	22 Hunterdon	9 Cumberland	23 Hunterdon
9 Ocean	23 Monmouth	16 Warren	
		JULY	

OBITUARY

PHILIP C. DOURESS, M.D.

Dr. Philip C. Douress, a prominent physician of Trenton, was killed in an automobile accident on August 30, 1934. He was a native of Trenton, and had practiced medicine in the city since his grad-

uation from Jefferson Medical College in 1912, except for naval service during the World War. He had been Surgeon to the Police and Fire Departments of Trenton for fifteen years.

THE WOMAN'S AUXILIARY

DEFINITENESS OF OBJECTIVES

A MESSAGE FROM THE PRESIDENT

The seventh year of the Woman's Auxiliary to the New Jersey State Medical Society has just come to a close. We are entering upon the eighth. From all appearances the Woman's Auxiliary is here to stay, and it is time for every physician and every physician's wife to fall in line with the idea.

In New Jersey we have fourteen active County Auxiliaries as follows: Atlantic, Bergen, Burlington, Camden, Cape May, Essex, Gloucester, Hudson, Mercer, Monmouth, Ocean, Passaic, Somerset, and Union.

We should like to see every county in New Jersey organized and working at the end of the year. We know that some of the counties are large and that the physicians are scattered far from one another, but distance apart is no excuse for not organizing.

We have just returned from Minnesota, where the towns and cities are widely scattered. We were interested to learn that some of the medical societies are made up of the physicians of three or four counties, and are successfully carrying on their work. We cannot let the mere matter of being apart deter us from organizing an auxiliary.

We are interested in our husbands' work; and, therefore, we should be interested in the auxiliaries.

We are making a special plea to the unorganized counties to form woman's auxiliaries this year; and to those already organized, to demonstrate their essential usefulness to the practicing physicians and to the County Medical Societies. The auxiliary has a great opportunity to mold public opinion regarding the importance of modern scientific medicine in our social structure.

There has been criticism by some physicians in regard to the work of the auxiliary. Some doctors have been afraid that we will be overzealous and will overstep our proper bounds as helpmates to the parent organization. This will not happen if physicians assign to the auxiliary a particular work they would like to see us do.

Other physicians have said there is nothing for us to do. After reading the suggestions which we are about to give, we challenge anyone to say there is nothing for us to do. We venture to suggest that if we concentrate our

efforts on fewer activities, we will accomplish more tangible results.

A DEFINITE PROJECT

Mrs. Hubbard, our President last year, suggested that each auxiliary form a Speakers' Bureau whose personnel shall be recruited from the County Medical Society. This year we desire to see this plan carried on to success.

Public Health Education is a field in which the auxiliary can render necessary service along the lines undertaken by the County Medical Societies.

The County Societies will appoint members who are willing and able to address organizations of civic or fraternal nature.

The auxiliary will make arrangements by which lay organizations will invite medical speakers to address them.

The auxiliary women are in a peculiarly fortunate position of contact with the physicians on the one hand, and the social and welfare organizations on the other. They can complete a connection between the two groups—professional and lay—and can do what no other group has as yet succeeded in doing.

We have been placing doctors' wives on public health committees in local health organizations, and these women have been instrumental in placing men and women who can speak with authority and knowledge on public health subjects on the programs of their clubs. It is our desire that the County Societies shall supply us with lists of speakers and their subjects. We will make the appointments for them to address the lay organizations.

Last year, in Camden, we saw over 200 representatives of women's organizations listen to Dr. Stanley Rieman, of Lankenau Hospital in Philadelphia, give a talk on cancer. The women were so pleased and grateful for the information given in his talk that we were requested to supply more talks like it. This shows that the people are becoming health minded—and for this attitude our auxiliary is largely responsible.

We ask for cooperation from the County Medical Societies in this educational undertaking. It has the approval of the State Medical Society and comes under our own public relations work.

There is another important work for us to do which comes under the title of the Society for the Relief of the Widows and Orphans of Medical Men of New Jersey. We cannot stress the importance of this work too strongly. (Journal, August 1934, page 496.)

We will have the honor and pleasure of entertaining the National Auxiliary next year for the American Medical Association meets in Atlantic City in June, 1935.

In summarizing this news letter, I again repeat our threefold objective:

1. We have a Woman's Auxiliary in every county in New Jersey;

2. We form a Speakers' Bureau in every county;

3. We become interested in and more informed about the Physicians' Widows and Orphans Society.

It is our earnest desire to coöperate with the medical societies; and we shall encourage constructive criticism and appreciate positive suggestions. With coöperation and unity, we can accomplish our projects.

MRS. A. J. CASSELMAN, President,
Woman's Auxiliary to The Medical
Society of New Jersey.
301 North Second Street, Camden.

AN OPPORTUNITY

The President of the Woman's Auxiliary to The Medical Society of New Jersey has suggested a practical line of work which the Auxiliary is peculiarly well fitted to do. Its initiation will require the authorization of the Medical Society and its continuance the hearty coöperation of physicians.

The specific suggestion of Mrs. Casselman, the State President, is that the Auxiliary shall be the agency for a Speakers' Bureau which each county society shall form. The object of the Bureau is to choose a list of members who shall be prepared to address meetings on public health subjects on the call of the Auxiliaries. The audience will be wo-

men's clubs, civic societies, and school organizations, all of whom are leaders in civic projects involving public health activities.

The County Medical Societies must take up the work of popular medical publicity in order that the people generally shall habitually turn to the *Medical Society* as the principal source of information regarding all problems connected with medical service. Every community has one or two public health plans submitted to it in the course of a year; but the civic leaders generally have yet to form the habit of seeking advice from the *County Medical Society*. The Auxiliary offers a practical solution of the problem of publicity regarding the work of the medical societies.

Burlington County

Reported by Mrs. L. M. Hornberger

The last meeting of the Auxiliary to the Burlington County Medical Society was held June 20, 1934, at the summer home of Mrs. Lyman B. Hollingshead at Nedford Lake Colony with a box luncheon.

The Hygiene Committee reported Hygeia would be placed in the High Schools of the county with money raised by a card party. The President and Delegates reported on the State Convention held in Atlantic City in June.

It was decided to hold our meetings more frequently during the coming year than we have done previously and it was suggested that we meet every two months rather than four times a year; our first meeting to be held in September.

Our program for the next year was outlined; and our chief aim being to raise money for our county

hospital, to be spent for specific needs. Committee Chairmen were appointed for this purpose.

The officers were elected for the ensuing year, as follows:

President, Mrs. G. E. McDonnel, Mount Holly.
Vice-President, Mrs. M. M. Schisler, Florence.
Treasurer, Mrs. L. B. Hollingshead, Pemberton.
Secretary, Mrs. J. H. Hornberger, Roebling.

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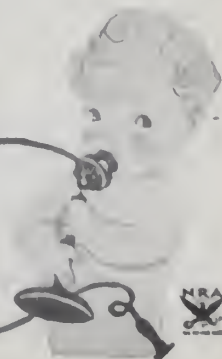
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The International Assembly of the Inter-State Postgraduate Medical Association of North America will be held in the Public Auditorium, Philadelphia, Pennsylvania, November 5-9, 1934. Many distinguished teachers and clinicians will appear on the program. A major list of the names of the contributors to the program, with other information, appears on page XI of this Journal. All members of the New Jersey Medical Society are cordially invited to attend. Registration fee of \$5 admits all members of the profession in good standing.—Adv.

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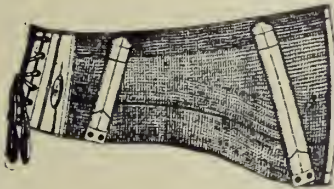
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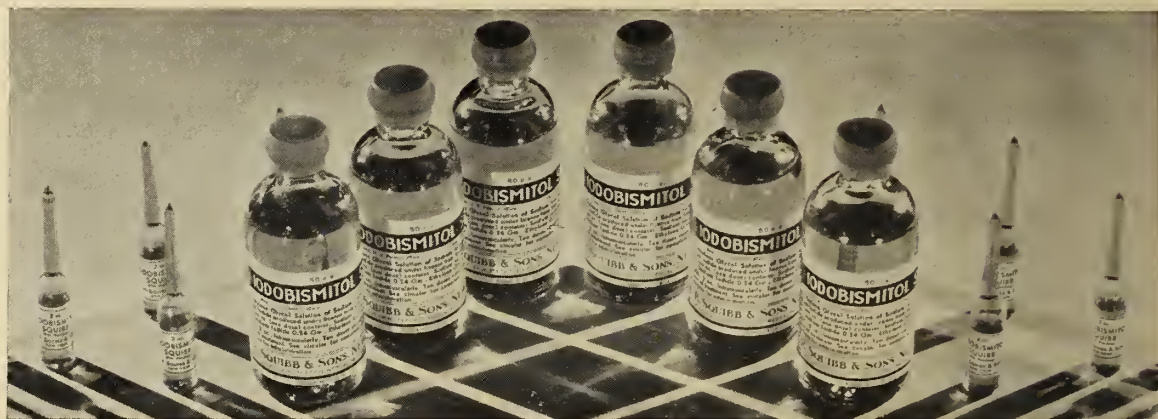
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1920

1934

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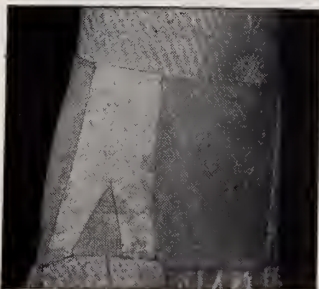
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1911

"The limits of assimilation of the different sugars vary and are as follows:

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"Grape sugar: In one-month baby, 8.6 grams per kilogram (Greenfield).

"Galactose: No accurate data.

"Levulose: (Lower for babies than adults.) One gram per kilogram (Keller).

"Maltose: Over 7.7 grams per kilogram (Reuss).

"Lactose: 3.1-3.6 grams per kilogram (Grosz).

"Cane sugar: Probably about the same as lactose (Reuss)."—*J. L. Morse, and F. B. Talbot: Physiology and pathology of the digestion of the carbohydrates in infancy, Boston M. & S. J., 164:852-855, June 16, 1911.*

1912

"Maltose has for many years been considered one of the most valuable of infant foods in modifying milk formulas; but the German school in the last few years has called special attention to the value of this sugar as a substitute for milk and cane sugars in conditions of intestinal fermentation. It is more easily assimilated and more rapidly absorbed than lactose or saccharose and it may be taken therefore by the infant in larger quantities without producing sugar fermentation."

"Maltose is especially indicated in the feeding of very young and delicate infants, and in all cases where either milk or cane sugar has produced intestinal fermentation and sugar intoxication. In the feeding of maltose it has been found advisable to combine it with about equal parts of dextrin. In Germany, and later in this country, 'Soxhlet's Nahrzucker' (which contains maltose 52.44 per cent., dextrin 41.26 per cent., and sodium chlorid 2 per cent.) has been largely used. Mead's Dextrin-Maltose (malt sugar), which contains about equal parts of dextrin and maltose, is a similar preparation which may be used instead of milk sugar or cane sugar for modifying milk mixtures."—*B. K. Rachford: Diseases of Children, D. Appleton & Co., New York, 1912, p. 125.*

1913

"It is well to start with one ounce (albumin milk, or albumin-buttermilk) to every pound of body-weight in the twenty-four hours, increasing gradually until two or three ounces to the pound of body-weight are being given. Then add sugar, preferably a malt sugar, about one-fourth of an ounce at a time to the twenty-four-hour quantity, until an ounce or an ounce and a half is being given."—*J. Foote: Principles of treatment in malnutrition and atrophy of infants, Interstate M. J., 20:1913, No. 6.*

1914

"Milk sugar and cane sugar may be used in infant feeding, but my preference is for malt sugar. Mead and Johnson put up a convenient preparation which they call Dextrin-Maltose and which consists of maltose 51 per cent., dextrin 47 per cent., sodium chloride 2 per cent., and which has a food value of about 110 calories per ounce."—*J. A. Gannon: Whole milk dilutions in feeding normal infants, Washington Med. Annals, 13:38-43, Jan., 1914.*

1914

"Dextrin-maltose causes the greatest gain in weight, cane sugar less, and lactose produces the least gain."—*M. S. Reuben: Observations on milk station infants, Arch. Pediat., 31:176-196, March, 1914.*

1914

"A composite opinion of the sugars is in favor of dextrin-maltose, milk sugar and cane sugar in the order named."—*R. A. Strong: Essentials of modern artificial feeding of infants, Lancet-Clinic, March, 14, 1914.*

1914

"Experiments show that sugars vary in their rate of absorption, some being assimilated rapidly, while others distribute their nutriment over a longer period. For example, maltose is most promptly assimilated, cane sugar next and milk sugar slowest."

"The condition in which dextrin-maltose is particularly indicated is in acute attacks of vomiting, diarrhea and fever. It seems that recovery is more rapid and recurrence less likely to take place if dextrin-maltose is substituted for milk sugar or cane sugar when these have been used, and the subsequent gain in weight is more rapid."

"In brief, I think it safe to say that pediatricians are relying less implicitly on milk sugar, but are inclined to split the sugar element, giving cane sugar a place of value, and dextrin-maltose a decidedly prominent place, particularly in acute and difficult cases."—*W. D. Hoskins: Present tendencies in infant feeding, Indianapolis M. J., July, 1914.*

1915

"In the severe cases (of diarrhea) he (Benson) uses Finkelstein's casein milk with malt sugar. He also believes that dextrin-maltose is

to be preferred to milk sugar or any other sugar, as the infants gain more rapidly and digest more easily this form of sugar."—*R. A. Benson: Observations on 1,500 artificially-fed infants, Med. Century, Feb., 1915, p. 33; abst. Arch. Pediat., 32:556-557, July, 1915.*

1915

"Until very recently we have taken it for granted that milk sugar was the best, but now many consider that malt sugar is even better. However, the malt sugar is not used in its pure state, but in the form of extracts, as dextrin-maltose."—*E. B. Lowry: Your Baby, Forbes & Co., Chicago, 1915, p. 162.*

1915

"Cane-sugar (saccharose), like most of the other disaccharids, is not absorbed as such, but must first be split by the invertase of the intestinal secretion into the two glucoses, dextrose and levulose, which are readily absorbable. Maltose (malt-sugar) occupies an exceptional position among the disaccharids, in being partly absorbable as such. This is probably due to the fact that it can be split not only by the maltase of the digestive juices, but also by the same ferment being present and active in the circulating blood (Chittenden and Mendel)."

"Anticipating a little, we may mention that all cases, in which lactose may advantageously be replaced by other carbohydrates, are pathological, and without exception the result of unsuccessful attempts at artificial feeding; they will therefore be discussed under that head."

"Dextrin, intermediate between sugar and starch, is physiologically nearer to the former; we shall have occasion to see that, under certain conditions, it may supplement sugar very advantageously. Given together with maltose, it materially delays the fermentation of the latter; Stolte observes that the more complex the carbohydrate the longer fermentation is postponed."

"All malted foods contain dextrin, and there is reason to believe that their value largely depends on their being somewhat complicated; such, at least, is the opinion of Usuki and Stolte, who believe that a mixture of carbohydrates is more slowly absorbed than a pure sugar, and therefore tends to check fermentation in the intestine. Southworth explains the matter more definitely, by attributing the antifermentative action entirely to the dextrin, which is not fermentable as such, but only after it has been split into maltose, a process that takes place only gradually, and in the later stages of digestion."

"I make it a rule to give the ordinary formula with dextrin-maltose whenever the usual milk or cane-sugar mixtures seem to cause excessive fermentation and colic, or are attended with the evacuation of soap stools. I decidedly prefer this, as a preliminary measure, to going over at once to some very low fat combination, which can only be a temporary makeshift at best. I also find dextrin-maltose an excellent addition to albumin-milk when the first object of that food has been achieved and a gain in weight is desired; in this way I have succeeded in feeding albumin-milk far beyond the period usually advised, with highly gratifying results."—*F. L. Wachenheim: Infant-Feeding: Its Principles and Practice, Lea & Febiger, Phila., 1915, pp. 31, 33, 146, 168.*

1915

"The infant with diarrhea and vomiting is given nothing but tea for from twelve to twenty-four hours, no longer, and then the albumin milk is commenced, not over 5 gm. ten times a day, with 3 per cent. of a maltose-dextrin mixture. The amount of albumin milk is increased by 50 gm. each day until the daily ration totals 300 gm. After the weight has become stationary, carbohydrates can be added up to 5 per cent. of the maltose-dextrin mixture."

"Albumin milk is not so uniformly effectual in dysenteriform diarrhea as in cholera infantum. When seems to act better, diluted half and half with oatmeal gruel. After the starvation period he gives 50 gm. of the whey and increases by 50 gm. daily with equal amounts of oatmeal gruel. As improvement sets in 3 per cent. of a dextrin-maltose preparation can be added."—*L. Langstein: Cholera infantum and other severe diarrheas in infants, Therap. Monatsch., V. 29, August, 1915; Abst. J.A.M.A., 65:1314, Oct., 7, 1915.*

1916

"Dextrin-maltose, having a higher absorption tolerance than the other sugars, is less likely to cause intestinal disturbances when large amounts of it are given."—*H. R. Mixsell: A brief résumé of the role of carbohydrates in infant feeding, Arch. Pediat., 33:31-30, Jan., 1916.*

1916

"In cases of malnutrition, and indigestion in infancy, 'The appetite improves rapidly, and the stools soon become normal in appearance, if the sugars are intelligently prescribed. By this I refer to proper proportions of dextrin and maltose. When there is a tendency to looseness, I have used the preparation known as 'dextrin-maltose,' for the extra carbohydrates; . . ."—*M. Ludd: Further experience with homogenized olive oil mixtures, Arch. Pediat., 33:501-512, July, 1916.*

Continued down to 1934

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"There are those who would like to let down the bars to self-medication. Yet the fact is that during the last few generations the average span of human life has been extended ten years, chiefly through the discoveries of medical science.

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years acquiring an education on the care and repair of the most marvelous mechanism on earth—the human body. But they would readily admit that this education does not qualify them for telling railroad executives how to solve transportation problems or impressarios how to stage an opera. The work of the world needs many kinds of specialized knowledge, but certain it is that each field of work will be best managed by those who know it best."—From Mead Johnson & Company's announcement in Hygeia, August, 1934.—Adv.

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The July issue of the *Texas State Journal of Medicine*, commenting editorially on the efficiency of committees and employees, says:

"The affairs of the Association are so extensive and ramify in so many directions, that it would be clearly impracticable to depend upon whole-time employees throughout. The income of the association, primarily from dues, is not sufficient for that.


"There are, as a matter of course, a certain number of paid employees who look after the routine. Even so, policy and procedure, in the most part, is determined by unpaid agents. If a paid employee does not function satisfactorily, he may be discharged. If the unpaid employee does not function, nothing can be done about it.



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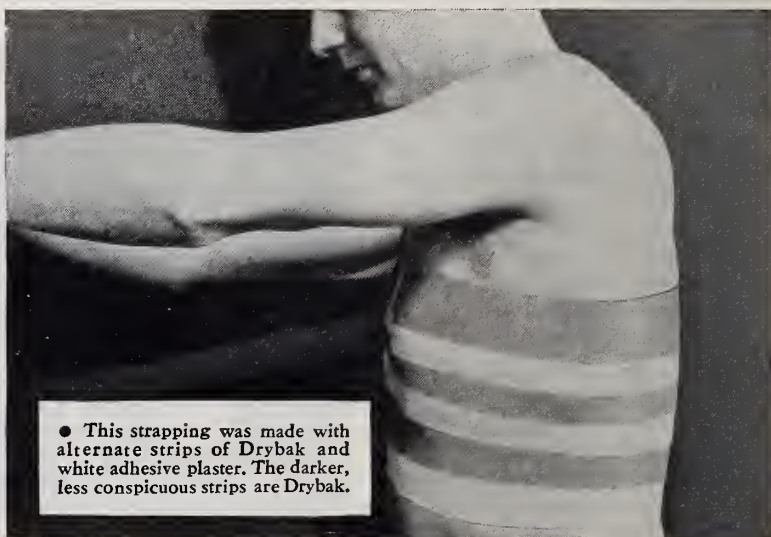


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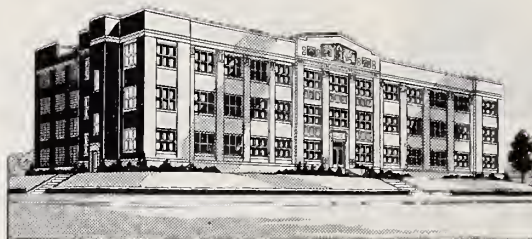
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



EDITOR OF
THE JOURNAL
FRANK OVERTON, M.D., Dr. P.H.

OFFICES OF THE SOCIETY—137 EAST STATE STREET, TRENTON, N. J., TEL. 9330
EXECUTIVE SECRETARY—LEROY A. WILKES, M.D.

Each member of the State Society is entitled to receive a copy of THE JOURNAL every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.

Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.

Officers, Trustees, Councilors and Committees of the Society are listed on page xx of the Advertising Section.

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OCTOBER, 1934

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EDITORIALS

Conference of County Secretaries and Reporters

The time is approaching for the tenth annual conference of the Secretaries and Reporters of the County Medical Societies of New Jersey. The Conference is the tangible connection between the county societies and is the central organization of The Medical Society of New Jersey, whose staff at 137 East State Street, Trenton, has the facilities for communicating promptly with all the county societies and advising their officers so that they will function with aims and methods which conform to the plans and policies of State Society as outlined by the House of Delegates.

It has been suggested that the principal topic for consideration at the next conference shall be "Plans for the Coöperation of the County Societies with One Another, and with the State Society".

The medical phase of the Emergency Relief Administration affords a striking example of the interdependence of all persons and agencies engaged in giving medical relief. The plan in operation in New Jersey requires distinct duties to be performed by three medical groups:

1. The individual physicians, who perform the services.

2. The county medical societies, whose committees audit the doctor bills which the Government pays.

3. The State Medical Society, which enters into agreements with the governmental agencies regarding the conditions under which medical relief shall be supplied.

Every county society of New Jersey, large or small, is concerned with medical relief and must give an account of its activities in that project. Many other problems of mutual interest are under consideration by the societies. How to coöperate in the exchange of information with one another and with the State Society is a proper subject for discussion at the coming Conference of Secretaries and Reporters.

The Conference will afford an opportunity for each participant to express his views regarding methods of obtaining a concert of action among the county societies, while each retains its individuality and initiative.

States in the Order of Numbers of Members of State Society	Area Square Miles	Population	Population per Physician	Number of Physicians	Number of Members of State Society	Per Cent Members of State Society	Fellows A. M. A.	Per Cent of Members Who Are Fellows A. M. A.	Non-Member Subscribers to A. M. A. Journal	Total A. M. A. Fellows and Subscribers	Per Cent of Physicians Receiving A. M. A. Journal
1. New York	47,654	12,965,000	568	22,812	13,074	57	8,278	63	4,810	13,088	62
2. Pennsylvania	44,832	9,787,000	790	12,608	7,831	62	4,941	63	2,200	7,141	50
3. Illinois	56,043	7,826,000	678	11,504	6,879	59	4,301	63	2,275	6,576	50
4. Ohio	40,740	6,798,000	775	8,769	5,168	59	2,948	57	1,354	4,302	50
5. California	155,652	6,062,000	577	10,490	5,167	49	3,359	65	1,960	5,319	53
6. Massachusetts	8,039	4,318,000	615	7,014	4,619	66	2,801	63	1,173	3,974	60
7. Texas	262,398	6,023,000	900	6,679	3,879	58	1,583	41	692	2,275	35
8. Michigan	57,480	5,043,000	886	5,678	3,218	55	1,971	61	858	2,829	51
9. Missouri	68,727	3,668,000	658	5,570	3,212	58	1,643	61	684	2,327	41
10. NEW JERSEY	7,514	4,193,000	853	4,915	2,899	58	1,918	61	1,300	3,218	65
11. Indiana	36,045	3,291,000	812	4,049	2,807	69	1,474	66	495	1,969	49
12. Minnesota	80,858	2,594,000	819	3,174	2,212	70	1,280	58	480	1,769	58
13. Iowa	55,586	2,482,000	790	3,141	2,191	70	1,210	55	425	1,635	53
14. Wisconsin	55,256	2,992,000	806	3,302	2,121	64	1,387	65	531	1,918	62
Totals for 14 largest States....		79,044,000	725	109,705	65,277	59.8	39,094	59.5	19,237	58,340	53
Totals for the United States		125,690,000	814	160,000	98,040	61	58,100	59	21,700	79,800	50

Table Showing the Standing of The Medical Society of New Jersey Among the Fourteen Largest State Societies and the American Medical Association

The Size of New Jersey Medically

Casual remarks heard during conversations at the A. M. A. Conference of the Secretaries and Editors of State Medical Societies on September 21 and 22, 1934, revealed the current impression that New Jersey is a *small* state from a medical society point of view; but a study of the statistics of the state medical societies and the American Medical Association discloses a different picture.

MEMBERSHIP RELATIONS

Among the states of the Union, New Jersey ranks as follows in its groups of membership relations:

Number 9 in population.

Number 10 in the number of its physicians.

Number 3 in its population per physician.

Number 8 in the percentage of its physicians who are members of the State Medical Society.

Number 9 in the proportion of members of the State Society who are Fellows of the A.M.A.

Number 1 in the percentage of physicians who receive the Journal of the A. M. A.

The data from which these conclusions are drawn are:

1. The A. M. A. Directory, 1934 Edition.
2. The A. M. A. Journal, May 5, 1934.
3. The A. M. A. Journal, August 15, 1934.

These statistics are set forth in the table on the opposite page. No claim for absolute accuracy is made for these figures, for the numbers given in the sources are not always for the same year; but they are sufficiently accurate to give a general picture and impression of New Jersey's rating among the other states.

Four striking facts are disclosed by the table:

1. Approximately 60 per cent of the registered physicians of the United States are members of their State Medical Societies.

The percentage in New Jersey is 58.

2. Approximately 60 per cent of the members of State Medical Societies are Fellows of the A. M. A.

The percentage in New Jersey is 61.

3. Approximately 50 per cent of the registered physicians of the United States receive the Journal of the A. M. A.

The percentage in New Jersey is 65—the highest of any state.

4. The number of New Jersey physicians who receive the Journal of the A. M. A. is 8 per cent greater than the number of members of the Medical Society of New Jersey. In only two other states is the percentage of A. M. A. Journal subscribers greater than the number of members of the State Societies—California 2.9 per cent greater, and New York with less than one per cent excess.

The physicians of New Jersey are loyal to the American Medical Association and the ideals for which it stands.

The standing of New Jersey would be still higher if the figures of the 1931 edition of the A. M. A. Directory were used, for during the last three years the influx of physicians into the State has been abnormally large and unexplainable. (See editorial in Journal of September 1934, page 501.)

NUMBER OF WORKING MEMBERS

The influence that a medical society has in a community depends largely upon the proportion of its members who are active workers. The policy of The Medical Society of New Jersey is that, when it undertakes a new piece of work, it assigns the task to a committee whose members are interested in that activity, thereby avoiding an overload upon any member, and yet insuring a working personnel that is anxious for the success of the project.

The work of The Medical Society of New Jersey is done by twenty-five committees composed of 175 individual members, among whom the officers of the Society are distributed. The list of the committees and their personnel is printed in each issue of The Journal, two pages being required.

Each State Committee works on the plan of duplicating its own form of organization in each county society; and of directing and inspiring the local members to develop their own methods suited to their peculiar local needs

and conditions. The total number of members on the local committees exceeds that on the State Committees.

Altogether at least fifteen per cent of the members of The Medical Society of New Jersey give active service as officers or committeemen performing essential tasks by methods that are clearly defined and coördinated.

The Medical Society of New Jersey excels not only in the number of its active workers, but also in their unity of objectives and methods.

The policy of every member doing his part in developing a medical service to meet local conditions, will be a satisfactory answer to the proposals that the government should assume the dictation of the practice of medicine.

Personal Contacts Increase Leadership

The A. M. A. Conference of Secretaries and Editors of the State Medical Societies, held in Chicago, on September 21 and 22, was enlightening to those who were privileged to take part in the proceedings and enjoy the opportunity to discuss problems with the leaders of the national organization. Those who had attended previous conferences noted the development of a relation, both cordial and confidential, between the staff of the national organization and the leaders in the State Societies similar to the cordiality which has grown up between the General Staff of the Army of the United States and the Reserve Officers.

ORGANIZATION OF THE MEDICAL FORCES

The rank and file of the organized medical forces of the United States consists of 98,000 physicians, each engaged in a personal combat with the forces of disease and death. Each member of that vast army is a potential leader, with opportunities to rise in influence and in respect among his companions.

The members of the medical army are organized in 2000 "companies"—the county societies—each under a President with his staff of subordinate officers and committees.

The counties, in turn, are organized in 48 "regiments"—the state medical societies—each with a President and his staff of officers and committeemen.

The states are organized in a National body—the American Medical Association—under a President and a General Staff of assistants, each of whom is an expert in his own field.

PLANNING AND ADMINISTRATION

The officers of the armed forces of the United States perform two lines of duty:

1. Planning.
2. Administration.

The function of planning implies authority to carry out the plans made by a central staff; but the principal function of the officers in all the grades is *administrative leadership*. Each member of the medical force is expected to show initiative and enthusiasm in developing and applying the means of carrying out those policies, each in his own field. Thirty thousand medical officers—one-third of the medical profession—who served in the World War, of whom a large proportion remained in the Reserve Corps, can testify to the value of these principles of planning and administration.

PERSONAL CONTACT

An essential and predominating element in any working group is the *morale* of every member, no matter what may be his rank or position.

Morale depends on the personal contact of every leader with those with whom he comes in contact—with those above him in rank as well as those below him. Caesar was successful as a general because he knew every soldier of his own Tenth Legion by name. In such a group authority and command are scarcely noticeable, except on parade; but wise *administrative leadership* is always in evidence.

The personal contact of the officers of the county societies with their members is the

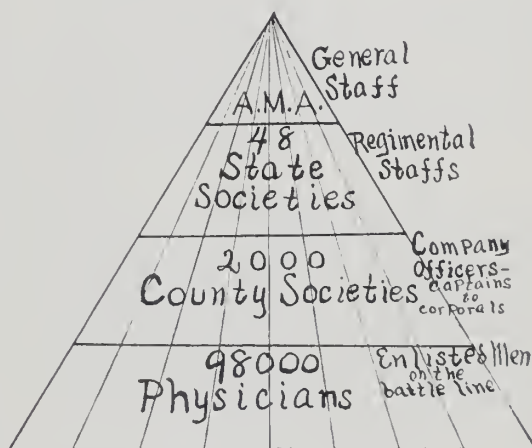
secret of the success of the work of the local organizations. In them the element of authority is almost absent, while *personal leadership* is the inspiring force which insures united action.

The power of personal contact is also evident in State Society administration, although it cannot be applied to its fullest extent by volunteer leaders who can give only a limited amount of time to their office and duties. The need is being met to an ever-increasing extent by the employment of Executive Secretaries and Editors on full time to carry out the details of the plans and policies determined at the regular meetings of representatives of the organizations.

The American Medical Association is expanding its staff so that a more extensive personal contact can be maintained with the State Societies. While the staff was limited in the number of its personnel, its leaders had to make their contacts by means of general statements of policies, leaving their administration to the Societies of the States and Counties. But with the gradual increase in the personnel of its staff, a greater degree of personal contact with the officers of the component societies is being made. One evidence of the expansion of its work is that, since all available space in the A. M. A. building is used for administrative purposes, the Conference of Secretaries and Editors had to be held in a hotel. Another item of evidence was the presence of the members of the staff at the ses-

sions of the conference, not so much for formal speaking, as to be ready to meet inquirers on a friendly basis, and aid them in their problems. Their eagerness to receive information from the delegates as well as to give advice was evident.

The policy of friendly contact between the members of the staff of the A. M. A. and the leaders of the State and County Societies will insure a high degree of morale of the members of the medical forces, and will lead to united action in the campaign against the forces of disease and death, and of improper medical service.



The diagram illustrates the possibilities for efficient service when these contacts are direct and friendly, and the principle of personal *coöperation in administration* is broadly applied.

Headquarters for County Societies

The importance of every society is becoming increasingly evident. The Nominating Committee of the State Society, for example, consists of the last Past-President and one representative from every county society, each with an equal vote; and each county society determines its own fee list for the administration of the Doctors' Lien Law; and any society may have an influence with its legislator who may determine an important medical policy for the entire state.

Not a day passes without the central office having occasion to call an officer of a county society on the telephone. It is easy to communicate with the Secretaries of the larger societies that maintain central offices; but it is often hard to reach the Secretaries of the smaller societies, especially those of rural counties.

In order that a County Society may function with a modern standard of efficiency, the

minimum requirements of its Secretary's office are as follows:

1. A definite office hour when the Secretary or his representative may be reached by telephone.

2. A special drawer or box in which letters and other communications may be filed.

3. Stationery containing the names, addresses, and telephone numbers of the principal officers.

Can every Secretary comply with these simple requirements? How to do so might be a practical subject for discussion at the Conference of County Secretaries and Reporters.

Permanent Usefulness of The Journal

With the great increase in the scope of activities of the medical societies of the several states there is a growing appreciation of the permanent value of the Journal to every member. Editors of State Journals frequently call attention to their state publication as a source of information regarding problems to which specific answers have been announced. Members glance through their journals and note items of information which they intend to read with care at a convenient time. Then when a procedure comes up at a society meeting, the Journal may not be available for reference, or the item may have been in a previous number which cannot be found amid a pile of other medical periodicals.

Every effort is made by the Publication Committee to make the Journal of The Medical Society of New Jersey the repository of

reports of activities, and decisions regarding policies and procedures which have been determined in the meetings of the societies. Inquiries coming to the central office of the Society regarding these decisions could usually be readily answered by reference to a specific page of a certain number of The Journal, but it is often necessary to supply the inquirers with that issue of The Journal, or a copy of the article.

This number of The Journal is of special value to every member, for it contains the Constitution and By-Laws of the State Society, to which every member may have occasion to refer at any time.

It should be easy to devise a simple method by which every member may preserve his Journal. How to do this is a proper topic for discussion at the coming meeting of the County Secretaries and Reporters.

Individual Responsibility

The responsibility for carrying out the policies of a medical society of a county or the state rests upon each individual member. No physician has a right to complain about the maintenance of a clinic for immunizing children against diphtheria unless he himself keeps a "Public Health Hour" during which he will immunize children who otherwise would go to a clinic.

About one thousand physicians have signed agreements to keep a "Public Health Hour",

but that is only one-quarter of the number of physicians who practice medicine in New Jersey. The State Department of Health is embarrassed when a health officer who is conducting a clinic sends a request for free biologicals on the ground that not one of the dozen physicians of the town had signified his willingness to participate in the Public Health Hour (see page 608). There would be no free clinic in that village if every doctor should sign an agreement to immunize children in his office.

ORIGINAL ARTICLES

THE TREATMENT OF ERYSIPELAS IN INFANTS AND CHILDREN

Based on a Series of 116 Cases Treated at the Essex County Isolation Hospital During the Past Five Years

By KENNETH BLANCHARD, M.D., East Orange, N. J.,
and

HORACE O. BELL, M.D., Belleville, N. J.,

First Assistant Physician, Essex County Isolation Hospital

From the Pediatric Service of the Essex County Isolation Hospital, Belleville, N. J. Read before the Pediatric Section of The Medical Society of New Jersey at the Annual Meeting, June 6, 1934.

SUMMARY

We believe from our experience, that direct blood transfusions is the choice method of treatment in infants with erysipelas. While we do not expect spectacular results, still we feel we can often carry these infants over the critical period of infection and keep their resistance raised by repeated small transfusions better than any other therapy. Especially do

we think that immune donors should be used if available.

We have in the last two years practically discontinued giving antitoxin to infants under two years of age and relied almost entirely on transfusions. We have had no experience with the ultraviolet light or x-ray in treating these cases.

It is a well-known fact that no special form of therapy used in the treatment of erysipelas in infants has proved entirely satisfactory. Many methods of treatment have had their vogue and passed on, but the best method of treatment still remains a moot question. This is readily understood when we consider that erysipelas, running a most capricious course, may appear as a very serious, or as a relatively mild disease, and that statistics endeavoring to prove the therapeutic merits of one method of treatment must be subjected to most careful scrutiny before being accepted on their face value.

In a survey of the literature, one finds that many investigators have used only a small number of cases in arriving at their conclusions, and that percentages of cures, or deaths, in a small series cannot give a true picture of what might occur with a much larger number.

The disease is particularly fatal in infants. Kerley⁽¹⁾ gives it as 95 per cent in the newborn and 50 per cent in infants under one year of age. As the child grows older the mortality decreases. Over two years of age the mortality probably is less than 10 per cent under any form of treatment.

The severity of the infection is well known in infants and it usually extends very rapidly, often covering the entire body during its

course. It causes an immense amount of edema of the tissues and marked swelling. Taylor⁽²⁾ has found that in contrast to the usual invasion in the adult, of only the skin, by the streptococcus, it is usual in the newborn infant to find these organisms in abundance throughout the subcutaneous tissues, showing that the pathological picture in the latter is a much more extensive process.

It is our purpose to present a series of 116 unselected cases of erysipelas treated at the Essex County Isolation Hospital in the past five years. The tables show the age groups and the number of transfusions and antitoxin doses given, together with case fatalities in each group.

Before presenting our series, however, it seems appropriate to mention some of the methods of treatment advocated with a brief discussion. Probably the most commonly used are the following:

1. Local applications of antiseptic solutions such as iodine, mercurochrome, and ichthyol.
2. Local applications of soothing hot or cold lotions, such as cold water, magnesium sulphate, boric acid, etc.
3. Local treatment with ultraviolet or roentgen rays.
4. Non-specific protein therapy such as injections of milk or horse serum.

5. Transfusions of whole blood from normal or convalescent donors.

6. Specific erysipelas antitoxin.

The local treatment of erysipelas has proved very unsatisfactory when used alone, but it may be agreeably used as an adjunct to other forms of therapy, as has been done in our series of cases where cold saturated magnesium sulphate solution or cold boric acid solution was used in practically all cases. It has a local soothing effect and adds to the patient's comfort.

The ultraviolet rays have been strongly endorsed by many investigators, some of whom claim rather remarkable results from them.

König⁽³⁾ apparently was the first to try ultraviolet light in 1913, but was not impressed with the results, which were published in 1916.

Petenyi⁽⁴⁾ treated 14 cases with ultraviolet rays in 1921; five were newly born, with only two deaths.

Czepa⁽⁵⁾ reports favorably on 100 cases so treated.

Platou and Ude⁽⁶⁾ reported that in 79 cases treated with ultraviolet rays, a clinical arrest of the disease occurred in 92 per cent following one treatment. However, the ages of the patients are not stated.

Other recent investigators writing enthusiastically about this method of treatment are Davidson,⁽⁷⁾ Troup,⁽⁸⁾ Titus,⁽⁹⁾ and very recently Nightingale and Starr.⁽¹⁰⁾ The last named writers treated 27 cases over one year of age with one death, and 19 cases under one year of age with 7 deaths, the exact ages not being stated. They state that in their "Ideal" cases so treated there were 4 deaths in 11 cases under one year of age, or 36.3 per cent mortality.

Titus claims the beneficial effects from ultraviolet rays are due to four things:

1. The increase in local resistance to the sensitizing action of the bacteria.

2. The consistent effect of the energy upon the nucleoprotein of the bacteria themselves, which, however, is not sufficient to be classed as a germicidal action.

3. The superactivation of phagocytes.

4. The production of local inflammation and continued counterirritation through the

physical effects of the energy in creating a very marked erythema.

We may mention a few of the writers who recommend roentgen rays as a therapeutic agent, viz:

Platou, Schultz and Collins,⁽¹¹⁾ Widman⁽¹²⁾ and Altschul.⁽¹³⁾ This method of therapy is not so popular at this time, and Platou and others have more or less discarded it in favor of ultraviolet therapy.

Specific serum therapy has been used extensively in the treatment of erysipelas since its introduction by Birkhaug⁽¹⁴⁾ in 1926, when he published the results of sixty cases. He states that in the doses used, "the antitoxin causes a prompt amelioration of toxic depression, a critical fall in temperature and pulse rate, prompt fading of the erysipelatous lesion and rapid absorption of the blebs and edema in the affected areas."

Symmers and Lewis⁽¹⁵⁾ in 1927 reported on 131 patients at Bellevue Hospital. Later, in 1928, Symmers⁽¹⁶⁾ reported a series of 705 cases, and again in 1932, Symmers and Lewis⁽¹⁷⁾ reported the results of treatment of 3311 patients. They claim that the duration of the disease was reduced 60 per cent and the mortality 30 per cent. However, they make no note of the ages of the patients treated but apparently they were practically all adults.

Eley⁽¹⁸⁾ reported on 33 cases of erysipelas in infants treated with antitoxin with what he considers favorable results. He concluded that it was of definite value as a therapeutic agent in the treatment of infants. However, a careful scrutiny of his statistics shows that of the cases six months of age and younger, numbering 16, there were 9 deaths; a mortality of 56.2 per cent.

Berkhaug,⁽¹⁹⁾ in 1928, states that in association with physicians in Rochester, N. Y., he observed the results of the use of antitoxin in 36 infants averaging in age from 2 weeks to 2 years and states that if adequate doses of the antitoxin are administered during the first three days of the disease, recovery is prompt, and ends by stating that "the results obtained are commensurate with those observed in the treatment of diphtheria".

However, the enthusiasm for antitoxin is

AGE 1-6 Mos.	DURATION ON ADMISSION	LOCATION	No. TRANS- FUSIONS	No. DOSES ANTI- TOXIN	CURED	DEATH	REMARKS
28 days	2 days	Lower back, but- tocks, genitalia	2	0	yes		Disease followed incision of boil on buttocks.
5 months	2 days	Neck and face	1	0	yes		Complication of double otitis mastoiditis and chicken pox
6 months	2 days	Neck and face	1	3	yes		Disease followed double mas- toidectomy.
6 months	2 days	Face and neck	2	0	yes		No complications.
3 months	2 days	Buttocks, geni- talia, lower abdom.	5	0	yes		No complications. Blood cul- ture neg.
6 months	3 days	Left forearm and hand	2	0	yes		Disease followed incision into forearm for some infection.
3 months	7 days	Left leg and but- tocks	3	0	yes		No complications.
3 weeks	5 days	Both legs	1	1	yes		Abscess on buttocks. Otitis media and impetigo, g.c. oph- thalmia.
4 weeks	3 days	Buttock and lower body	0	1	yes		Possible bronchial pneumonia
1 month	2 days	Face, neck, body and extrem.	3	2	yes		Multiple abscesses and chick- en pox; in hospital 88 days
1 month	1 day	Face, scalp, neck, body, extrem.	2	0	yes		No complications.
19 days	2 days	Face, scalp, body, buttocks	0	2	yes		
3 months	4 days	Face	0	0	yes		Case very mild.
5 months	3 days	Legs, buttocks, genitalia	1	2	yes		No complications.
3 months	5 days	Head, body, extrem.	6	0	yes		Fever high for 4 weeks. No complications. (2 trans. from immune donor.)
3 weeks	4 days	Body	2	1		yes	Developed cellulitis and gan- grene of chest wall.
9 days	2 days	Vulva, thighs, lower abdom.	1	1		yes	Autopsy showed umbilical arteritis.
3 months	7 days	Face, scalp, neck, chest	2	0		yes	Developed Jaundice and probably general septicemia Disease followed cervical adenitis.
7 weeks	4 days	Face, body	2	0		yes	Autopsy showed pericarditis with effusion, toxic myocar- ditis.
7 weeks	5 days	Face, body	1	0		yes	Unable to retain food. Ab- domen distended, probably peritonitis.
3 weeks	3 days	Body, extrem.	0	0		yes	Child lived less than one day after admission. Lesions are doubtfully true cry- sipelas.
5 months	1 day	Face	1	0		yes	Autopsy showed right lobar pneumonia and streptococ- cic peritonitis.
7 days	4 days	Facial	0	0		yes	Erysipelas followed forcep injury to head. Also had paralysis of left arm.
1 month	1 day	Face, body, scalp	0	2		yes	Baby vomited, unable to re- tain feedings.
7 weeks	2 days	Head, body, extrem.	0	2		yes	Rapidly extending eruption over entire body.
4 months	6 days	Face, neck, scalp	1	0		yes	Autopsy showed no definite complications.
5 months	7 days	Face and upper trunk	4	1		yes	Very rapidly extending

Chart 1. 1 to 6 Months—27 Cases—12 Deaths—44.4 per cent Mortality.

AGE	DURATION ON ADMISSION	LOCATION	No. TRANS- FUSIONS	No. DOSES ANTI- TOXIN	CURED	DEATH	REMARKS
6 Mo.-1 Yr.							
11 months	1 day	Both legs	0	2	yes		Began as impetigo lesion. Temp. high one week.
8 months	3 days	Right leg and groin	1	1	yes		Disease followed incision of infected area.
8 months	2 days	Right leg	0	0	yes		Fever only 2 days.
1 year	4 days	Left arm, right leg	1	0	yes		Had lobar pneumonia and multiple abscesses of extremities.
1 year	3 days	Face, scalp	1	0	yes		Had double otitis, abscess of scalp and left arm.
1 year	2 days	Face	1	1	yes		No complications.
1 year	2 days	Face, scalp	1	0	yes		Disease followed left mastoidectomy. Moderately high fever only two days. Also had right mastoidectomy. Transfused once before admission. Positive blood cult before admission.
1 year	6 days	Left leg	1	0	yes		Developed abscess of left knee.
1 year	1 day	Face	0	0	yes		Had cervical adenitis which did not suppurate.
9 months	5 days	Right arm, left arm, face, body, extrem.	14	3	yes		Disease followed toxin anti-toxin injection in right arm. Arm incised. Eruption spread over entire body and extremities. Three transfusions from convalescent donor.
10 months	2 days	Facial	3	0	yes		No complications.
9 months	1 day	Left leg	0	0	yes		Disease followed burn of leg. Child also had bronchial pneumonia.
11 months	6 days	Face, neck	3	0	yes		Disease followed incision of cervical gland.
7 months	2 days	Lower trunk, buttocks, genitalia, legs	4	0	yes		Ran very high fever for 8 days.
7½ months	8 days	Head, body, extrem.	2	1	yes		Developed multiple abscess.
11½ months	4 days	Face	1	1	yes		
10 months	2 days	Right arm, body	2	1	yes		Ran high fever for 1 week. Also had several Alpine light treatments.
8 months	14 days	Right leg	0	0	yes		Ran very mild course. Temp. normal in five days.
10 months	4 days	Buttocks, legs, lower abdomen	1	0	yes		High fever for about 12 days. Developed abscess of left leg.
1 year	?	Face, scalp	1	2	yes		Disease followed old mastoid operation. Developed abscess of scalp.
1 year	6 days	Left leg	0	1	yes		Ran high fever for 4 days. No complications.
1 year	2 days	Face, scalp	0	0	yes		Had several doses of streptococcus vaccine.
7 months	1 day	Face	0	0		yes	Died within 24 hours after admission having a severe gastrointestinal intoxication with dehydration.

Chart 2. 6 Months to 1 Year.

AGE	DURATION ON	LOCATION	No. TRANS- FUSIONS	No. DOSES ANTI- TOXIN	CURED	DEATH	REMARKS
6 Mo.-1 Yr.	ADMISSION						
8 months	4 days	Head, neck, body extrem.	3	1		yes	Blood cul. positive for streptococcus. Autopsy diag- nosis general septicemia, bronchial pneumonia and multiple necrotic foci.
1 year	2 days	Face, scalp	0	0		yes	Disease followed by bilateral mastoidectomy. Autopsy re- vealed bronchial pneumonia and nephritis. Developed convulsions before death.
10 months	3 days	Face, scalp	2	0		yes	Disease followed bilateral mastoidectomy. Developed bronchial pneumonia and empyema.

Chart 2—continued. 6 Months to 1 Year—26 Cases—4 Deaths—15.4 per cent Mortality.

AGE	DURATION ON	LOCATION	No. TRANS- FUSIONS	No. DOSES ANTI- TOXIN	CURED	DEATH	REMARKS
One to Two Years	ADMISSION						
2 Years	5 days	Facial	None	None	Yes		.....
2 Years	4 days	Facial	None	Four	Yes		.....
13 Months	3 days	Right leg	None	None	Yes		.....
14 Months	7 days	Facial	Two	Three	Yes		.....
17 Months	5 days	Facial	Two	None	Yes		.....
22 Months	14 days	Legs and arms	None	One	Yes		.....
22 Months	4 days	Left leg	None	None	Yes		.....
20 Months	1 day	Facial	None	None	Yes		.....
21 Months	2 days	Left leg	None	None	Yes		.....
19 Months	7 days	Trunk and left extremity	Three	None	Yes		.....
18 Months	2 days	Facial	One	None	Yes		.....
2 Years	1 day	Forehead and scalp	None	None	Yes		.....
20 Months	2 days	Lower right leg	One	None	Yes		.....
2 Years	3 days	Right leg	Two	None	Yes		.....
2 Years	2 days	Facial	One	None	Yes		.....
19 Months	8 days	Facial	Three	None	Yes		.....
16 Months	5 days	Left leg	Two	None	Yes		.....
21 Months	3 days	Lower leg	One	None		Yes	Septicemia, cardiac failure.

Chart 3. 1 to 2 Years—18 Cases—1 Death—5.5 per cent Mortality.

not shared by many physicians of wide experience, as is evidenced by the constant effort to find a more accurate treatment.

McCann,⁽²⁰⁾ writing from Rochester also in 1928, does not feel that antitoxin was of value in the series of cases he studied. Of 15 children treated with serum there were 8 deaths. He presents statistics showing better results in non-treated cases than those treated, and concludes that the true value of serum in erysipelas will not be established until a more adequate analysis can be made of a long series of

cases with proper controls, untreated by the serum.

Blake⁽²¹⁾ does not believe that recovery from erysipelas depends to any great extent on the use of antitoxin and that theoretically antitoxin can be of very little value.

The use of whole blood or blood serum has been tried by many men. The use of convalescent serum was made at the Providence City Hospital in 1919, and reported by Jordan and Dustin⁽²²⁾ in 1924. Eighteen patients were treated with three deaths. Two showed ques-

AGE Two to Four Years	DURATION ON ADMISSION	LOCATION	No. TRANS- FUSIONS	No. DOSES ANTI- TOXIN	CURED	DEATH	REMARKS
4 Years	10 days	Leg	None	None	Yes		
3 Years	2 days	Lower leg	None	One	Yes		
3 Years	6 days	Legs	None	None	Yes		
2½ Years	8 days	Facial	None	None	Yes		
3 Years	7 days	Facial	Four	Two	Yes		
3 Years	2 days	Left thigh	One	None	Yes		
3 Years	3 days	Facial	Eight	Three	Yes		Negative blood culture
3 Years	1 day	Right leg	None	None	Yes		
4 Years	3 days	Left leg	Four	None	Yes		Osteomyelitis left leg. Blood culture positive for non-hemolytic strep.
3 Years	2 days	Facial	None	None	Yes		
4 Years	1 day	Facial	One	Four	Yes		
4 Years	3 days	Facial	None	None	Yes		

Chart 4. 2 to 4 Years—12 Cases—No Deaths.

tionable improvement. This was given intra-muscularly.

Borovsky⁽²³⁾ reports on 14 cases of erysipelas in children under one year with 10 recoveries and 4 deaths. He painted the lesions twice daily with 2 per cent mercurochrome and in addition used citrated blood, intramuscularly.

Brown,⁽²⁴⁾ of Toronto, advocated the use of exsanguination transfusions, claiming a striking drop in the mortality.

Schaffer and Rothman⁽²⁵⁾ used transfusions in infants with apparently good results. Nineteen cases were transfused with citrated blood; with 4 deaths; a mortality of 21 per cent. All transfused were 2 years or younger. The mortality in the untreated cases was 36.5 per cent.

In the series of cases here presented the tables are self-explanatory.

It will be noticed that of the 27 cases in the 1 to 6 months group, there were 12 deaths, or a mortality of 44.4 per cent. Thirteen received transfusions alone, 6 both antitoxin and transfusions, 4 antitoxin alone and 4 only local treatment. Of the 12 deaths in this group, 5 received transfusions, 2 antitoxin, 3 both antitoxin and transfusions and 2 neither, due to being moribund on admission. The causes of death may be seen from the tables.

In the 6 month-1 year group, there were 26 cases with 4 deaths, or a mortality of 15.4 per cent. In this group 10 were given transfusions, 7 both transfusions and antitoxin, 2 antitoxin, and 7 local applications only. Of the 4 deaths, 1 received both transfusions and

antitoxin, 1 was transfused only, and 2 had neither. Three died with bronchial pneumonia and the fourth had a severe gastroenteritis. Of particular interest in this group was a 9 months old infant having a severe erysipelas, following toxin-antitoxin administration and admitted five days after the onset. The eruption spread over the entire body. This child was given 14 transfusions, the last 3 of which were from a convalescent donor, and the child made a complete recovery.

In the 1-2 year group, there were 18 cases with only one death, or a mortality of 5.5 per cent. Nine cases were transfused, 1 was given antitoxin and 1 had both antitoxin and blood transfusions.

In the 2-4 year group, there were 12 cases with no deaths. Two were given antitoxin and 3 were transfused. Three were given the benefit of both antitoxin and transfusions. One very severe case of facial erysipelas had 8 transfusions and 3 doses of antitoxin, and made a complete recovery.

In the group from 4-14 years, there were 33 cases with 2 deaths, a mortality of 6.06 per cent. Two were transfused, 15 were given antitoxin and 3 had both antitoxin and transfusions. Of the two that died, one had a rheumatic carditis and the other was moribund on admission.

The method of transfusion used was the direct, with the syringe, cannula and Lindeman needle. Credit is due to Dr. Lewis Brown, of Newark, for his help and skill in perform-

AGE	DURATION	LOCATION	NO. TRANS-	NO. DOSES ANTI-	CURED	DEATH	REMARKS
Four to Fourteen Years	ADMISSION		FUSIONS	TOXIN			
7 Years	1 day	Scalp	None	None	Yes		
9 Years	8 days	Left elbow	None	None	Yes		
12 Years	2 days	Right forearm	None	None	Yes		
9 Years	13 days	Right leg	Two	One	Yes		
9 Years	7 days	Facial	None	None	Yes		
7 Years	5 days	Left leg	None	Two	Yes		
10 Years	4 days	Facial	None	Two	Yes		
9 Years	2 days	Facial	None	Two	Yes		
13 Years	4 days	Facial	None	Two	Yes		
9 Years	9 days	Left leg	None	Two	Yes		
6 Years	3 days	Facial	None	Four	Yes		
13 Years	5 days	Left knee	None	One	Yes		Strept. Hem. from knee.
13 Years	2 days	Groin	None	None	Yes		
10 Years	2 days	Left arm	None	None	Yes		
13 Years	6 days	Right leg	None	None	Yes		
14 Years	2 days	Facial	None	Two	Yes	Yes	Rheum. Carditis, bilat. Otitis media.
10 Years	4 days	Facial	None	Four	Yes		
10 Years	7 days	Facial	None	None	Yes		
8 Years	1 day	Right leg	None	One	Yes		
12 Years	2 days	Facial	None	None	Yes		
12 Years	5 days	Facial and Upper extremities	One	Two	Yes		Negative blood culture.
12 Years	5 days	Facial	None	One		Yes	Moribund on admission. Positive staph. septicemia.
7 Years	2 days	Facial	None	One	Yes		Chronic otitis media.
14 Years	1 day	Facial	None	One	Yes		
11 Years	4 days	Facial	None	None	Yes		
12 Years	7 days	Left leg	None	None	Yes		Staph. Albus of ankle.
10 Years	4 days	Facial	None	Four	Yes		
5 Years	7 days	Left arm	None	Two	Yes		
14 Years	5 days	Left thigh	One	None	Yes		
8 Years	7 days	Facial	Seven	Two	Yes		
14 Years	2 days	Right leg	None	None	Yes		
6 Years	10 days	Facial	One	None	Yes		
13 Years	2 days	Facial	None	None	Yes		

Chart 5. $\frac{1}{2}$ to $1\frac{1}{2}$ Years—33 Cases—2 Deaths—6.06 per cent Mortality.

ing most of these transfusions. The amount of blood given was about 6 or 8 c.c. per pound of body weight and repeated usually every other day.

The antitoxin used was mostly Lederle's concentrated, in 10 c.c. doses intramuscularly, regardless of age.

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THE PREVENTION OF ACNE VULGARIS IN ADOLESCENT CHILDREN

By STANLEY NICHOLS, M.D., Asbury Park, N. J.

Read before the Section on Pediatrics of the Medical Society of New Jersey at the Annual Meeting in Atlantic City, June 7, 1934.

SUMMARY

1. If seen early, ages 8 to 12, at the black-head stage, acne vulgaris and its disfiguring after-effects can be controlled in over 80 per cent of adolescent children.
2. The method is simple and consists mainly of keeping the skin dry and rather chapped by the use of mild and later stronger soaps, and lotio alba of increasing strength and concentration.
3. The preventive treatment should be regular, proportioned to the severity of the case, and continued to at least fifteen years of age in most cases.
4. This treatment will also help many cases even at the age of 12 to 14 when the condition is more established, but is not nearly as successful as in the younger group when the condition is in its incipency.
5. X-ray treatment should be reserved for cases persisting after puberty.

My reasons for presenting such a *minor* subject as acne vulgaris before this Pediatric Section are twofold:

1. This simple method of acne control seems to me to be a good example of preventive therapeutics.
2. While acne vulgaris is physically a minor ailment, psychologically it frequently becomes a major handicap in early life, particularly to young girls.

To adolescent girls it gives an unattractive appearance, jeopardizes their chances of marriage, is a social handicap, and becomes a definite mental hazard. Even in boys, rightly or wrongly, it often interferes with progress in business or profession, being often mistakenly interpreted as a sign of dissipation or some form of bad habits.

In my experience, it is frequently more difficult to correct a mental condition than a physical one. Therefore, it seems to me to be well worth while to present this preventive method of controlling a condition, which, while physically a minor one, often brings such a train of mental ills in its wake.

There is nothing original in this paper. It consists of a simple method, outlined to me by Professor George Miller McKee of the Dermatologic Department of the New York Post-Graduate Medical School. This method

I have followed during the past four years in the control of incipient cases of acne between the ages of eight and twelve years. I wish at this time to tender my thanks to Dr. McKee for his assistance.

DIAGNOSIS

Both the diagnosis and preventive treatment of acne vulgaris are very simple. Acne vulgaris often appears as early as eight or nine years of age. Children, especially girls, should be watched between the ages of eight and twelve for an oily type of skin, with a few black heads and papules and perhaps an occasional pustule about the center of the face. While this is the common age, these may appear at any time up to puberty. If mild, these manifestations may disappear. More commonly they get worse, the follicular orifices or pores enlarge, the skin becomes sallow, the pustules increase in number, and pitted scars and bad complexion constitute a permanent damage to the skin of the adolescent. If there is no preventive control, a psychic trauma ensues, and an inferiority complex makes its appearance in many cases. Acne vulgaris may also indicate endocrine imbalance, gastro-intestinal disorders, pelvic disturbances, sex irregularities, etc. From every point of view, it seems preferable to *prevent* and *control* acne,

rather than to attempt to cure it after it has become well established and has done a lot of damage to the skin. Therefore, a little acne before puberty should not be neglected, as it is possible in the vast majority of cases to control it to such an extent that it is hardly noticeable and does no harm. If this control extends through the period of puberty, it is then usually permanently cured.

X-RAY TREATMENT

Before we speak about the preventive control, I wish to quote Dr. McKee's feeling about x-ray treatment at this age. He says, "It is unwise to apply x-rays to these youngsters, except when especially indicated. If judiciously applied, no immediate harm is done, but at this time of life recurrences are common even after x-ray treatment—and, of course, there is a limit to the amount of x-ray that can be applied. It is better to hold x-ray in reserve, until after the age of puberty. Then if the affection persists and everything else has been done, x-ray should be used by all means."

PREVENTIVE TREATMENT

Scalp: If the scalp is oily, it should be washed every ten days with Castile Soap.

Face and Skin: The face and skin in these cases are usually greasy or oily. They must be made dry looking, with a slightly chapped appearance, and kept that way all the time. The treatment should be continued until at least the age of fifteen. Therefore, patience and persistence are necessary.

To make the skin dry, the face is first washed before going to bed with mild castile soap and fairly hot water; then well sopped for five minutes with lotio alba one-quarter strength (well shaken up) and allowed to dry on the skin and remain overnight, to be washed off in the morning. This treatment should be continued until the skin is dry and rather chapped. If at any time it gets too chapped, omit the lotio alba for three days. As the skin gets used to the mild castile soap and one-quarter strength lotio alba, increase the strength of the soap and lotion; using physicians and surgeon's soap, later tar soap, and

later still green soap. Also increase the lotio alba strength to one-half, three-quarters, regular strength; then later twice, four times and even eight times the normal strength. It is only necessary to increase these strengths of soaps or lotion if the skin does not stay dry and a little chapped. The skin should be inspected at intervals, usually monthly, to observe the control of the dryness. In about 10 per cent of cases it may be necessary to add resorcin. In a few stubborn cases the addition of beta naphthol or Vlemminckx Lotion may be found necessary to accomplish the drying of the skin. If the skin is difficult to keep chapped twenty-four hours a day, a day lotion without much visible precipitate on the skin may be used as follows: sodium Hypo sulphate $\frac{1}{2}$ dram, alcohol 1 oz., lime water 4 ounces, to be sopped on the face two or three times daily.

Patients who have a tendency toward acne are benefited by gradual exposure to the sun or artificial untraviolet radiation. Foci of infection, constipation, unbalanced diet, bad habits of any kind, and general hygiene should receive attention.

This very simple treatment has proved remarkably effective in 47 children between the ages of 8 and 12 during the past four years. Of these, 39 were girls and 8 were boys. In 37 cases, or about 80 per cent, after three months to four years of treatment, the acne is virtually unnoticeable and well under control. Five cases, or about 10 per cent, are much improved, and the same number moderately improved. Not a single case has become severe in this group, seen at the early stages of acne. An older group between 12 and 14, where the acne was more established, were put on the same treatment, with considerable improvement in many cases, but were far less successful than the cases which were started early on this course. It is my opinion that physicians, who see many children, should observe their skins closely between the ages of 8 to 12, especially girls, and try this simple method of preventive treatment on those showing the early signs of this condition. I am sure that they will be well pleased with the results, and prevent a good deal of unhappiness in the adolescents of the future.

X-RAY DIAGNOSIS OF PNEUMONIA

By JOSEPH E. ROBERTS, M.D., Camden, N. J.

Read before the General Session of the Medical Society of New Jersey in a Symposium on Pneumonia, in Atlantic City, June 7, 1934

The x-ray examination of the chest is a valuable aid in the diagnosis of pneumonia; and by serial roentgenograms the course of the disease may be followed from the stage of congestion, through the stages of red and gray hepatization, up to the time complete resolution has taken place.

The chest is of such construction that it lends itself well to x-ray study. The dense bony framework of the thoracic spine, sternum, ribs and shoulder girdle, the dense heart, and the air-filled lungs prove themselves, because of their widely different degrees of density, well adapted to study both by the fluoroscope and the roentgenogram.

Properly to interpret the findings as recorded on the x-ray film it is necessary to have a clear conception of what constitutes the normal limits of the variously recorded densities. The type of chest, the normal lung structure, the location of the three lobes of the right lung and the two lobes of the left, the normal contour of the domes of the diaphragm, the size of the so-called normal hilum shadows, and the position, size and shape of the heart, as well as a due sense of the average extent of the lung markings, are all essential to the interpreter before any proper evaluation of the pathological changes can be attempted.

The basis of value in the x-ray examination of the pathological chest rests on the fact that disease processes in the lungs cause a change in the density, which in turn results in differences of exposure of the x-ray film by the penetrating rays. The less dense the object through which the rays pass, the greater the illumination of the film; and the more dense the intervening object, the more the rays are obstructed and the less the illumination of the film. Thus our roentgenogram becomes a record of the various densities of the component parts of the composite object through which the rays pass.

FIRST STAGE

The first stage of pneumonia, that of congestion, is not often seen by the roentgenologist. It lasts but a short time. There is noted in this stage an increase in the lung markings due to an engorgement of the blood vessels. There is increased density at the root of the lungs and in the intermediate zone, and also some evidence of the pulmonic markings continuing into the peripheral zone. There is noted sometimes a slight haziness or veiling in the central lung field which rapidly increases as the exudate advances.

STAGE OF HEPATIZATION

The stage of red and the stage of gray hepatization have the same appearance. There is noted an area of diminished, to absent, illumination, or so-called opacity. This is usually quite homogeneous with absence of lung markings, and is limited anatomically by the lobe or lobes involved. With this increase of opacity or density in the consolidated lung there is no concomitant displacement of the mediastinal structures, though some lung compression may exist. If the fluoroscope be used, the diaphragmatic excursion is seen to be somewhat restricted and expansion on the affected side is diminished. During these two stages no aeration of the lung is observed.

In children lobar consolidation appears to occur more frequently in the upper than in the lower lobes, and the density is relatively greater than in adults. The lower lobes seem to be involved more commonly in adults than do the upper lobes. In children more frequently than in adults there is a partial consolidation, and this often starts in the peripheral portion of the lobe involved. In these cases x-ray examination is of particular value, for it is often difficult to get bronchial breathing in these incomplete involvements. This also holds true in central pneumonia, and in the migratory form. While in children the consoli-

dation often progresses from the periphery toward the center, in adults the process is more often from the hilum outwards.

STAGE OF RESOLUTION

After the crisis resolution rather quickly occurs. This is shown by the gradually increasing illumination of the consolidated lobe or lobes, until after a few days to perhaps ten or twelve days the lung returns to its normal appearance with no traces of the consolidation remaining. Resolution may be protracted, and still later may become organized and result in more or less complete fibrosis, often difficult to distinguish from fibroid phthisis. In the fibroid consolidation there is retraction and contraction with displacement of the mediastinal structures toward the affected side, with narrowed interspaces and with high fixed diaphragm. Massive collapse is differentiated from pneumonic consolidation by the signs of negative pressure on the affected side. The trachea and heart are pulled over toward the opacity and the diaphragm is high and the interspaces narrowed.

PLEURAL EFFUSION

In pleural effusion there is increased tension on the affected side, the heart shadow is often pushed over toward the unaffected side, the costophrenic angle does not show aeration, the apex does show illumination and the interspaces are widened and the diaphragm excursion much restricted.

BRONCHO-PNEUMONIA

In the broncho-pneumonias there are certain essential characteristics. The lesions are widely disseminated, different stages of the disease are noted on the same film and in various portions of the lung. The areas of consolidation are usually multiple and are smaller than in the lobar form, and are more patchy in character, and their density less homogeneous. There is here also the stage of congestion with irregular distribution of thickened pulmonic markings; and often the x-ray signs do not advance beyond this stage. In the stage of consolidation there appear patches of absent illumination or at least diminished transpar-

ency of various sizes. These may become confluent, forming larger areas until almost a whole lobe may be involved. The lung markings are thicker and more numerous and often remain so due to infiltration of the bronchial walls. Usually these cases of broncho-pneumonia become entirely resolved, but frequently there is some residue of the disease process. In either type if resolution does not take place, multiple or single abscesses may result. These are usually easy of determination, for the abscess cavity often contains air and fluid, and a fluid level can be demonstrated if the film be taken with the patient in the proper position.

OTHER CONDITIONS

The differentiation of pleural effusion, delayed resolution, and massive collapse from pneumonia has already been considered. There are at least two other conditions which at times are difficult of proper interpretation, viz. lung abscess and lung tumor. Usually in lung abscess the area of opacity is not limited to one or two lobes; the process is a slower one requiring days and even weeks, where as pneumonic consolidation is usually fully advanced in forty-eight hours. At the onset the differentiation may be impossible, but by serial x-ray examinations, the diagnosis may be certainly established. In tumor of the lung the appearance is most varied. The tumor is not confined anatomically to one lobe but extends across the interlobar fissures; and the margins of the opacity are hazy or feathery in appearance. Mediastinal tumors extend into the lung field, are usually well rounded and have their bases in the mediastinum.

The clinical data are essential to the absolute diagnosis of pneumonia, the roentgen signs being purely confirmatory. Close coöperation between the internist and the roentgenologist, so that each may have the benefit of the other's knowledge, will secure for the patient the most satisfactory results. The surgeon and too often the pathologist are also important factors in the final diagnosis of many of these cases; and certainly the surest way to advance our knowledge is by frequent conferences and interchange of ideas.

PRENATAL CARE AND ITS RELATION TO MATERNAL AND INFANT MORTALITY

By ROBERT L. DENORMANDIE, A.B., M.D., F.A.C.S., Boston, Mass.

Read by invitation before the General Session of the 168th Annual Meeting of the Medical Society of New Jersey at Atlantic City, N. J., June 6, 1934.

I appreciate the honor you have done me in asking me to speak to you today on prenatal care. It is the very foundation of good obstetrics, and that is what you and I are earnestly seeking to make available to all the women in this country, no matter what their circumstances may be.

In my student days we were told something of the care of the pregnant woman, but as well as I can remember, the words "prenatal care" were not in use. In 1907 the Association for Improving the Condition of the Poor in New York City assigned two nurses to visit in homes where there were pregnant mothers and to make sure that the mothers were connected with clinics or private physicians for supervision. In 1909 the Women's Municipal League of Boston provided a trained nurse to visit a chosen group of patients for instruction in personal cleanliness and the hygiene of pregnancy, and when it was found that any of these patients needed observation and treatment they were admitted to the Boston Lying-In Hospital for care.

These two instances were, I think, the beginning of organized prenatal work in this country. We all agree that it is now an established part of obstetric care, that it is one of the essentials of preventive medicine. If this is so, why do so few women have good prenatal care? In the recent study by the Children's Bureau of the maternal deaths in fifteen states over a two-year period, only one per cent of the cases had care of the quality which it is the right of every pregnant patient to demand.

It is not my purpose to reiterate all the details of the care of our pregnant patients, but rather to interpret these procedures. The patient's past history often leads us to investigate more carefully certain of the systems. The acute infectious diseases with their frequent disabling sequelae point at once to the heart and kidneys. A family history of tuberculosis

with exposure of the patient should lead us to investigate thoroughly the condition of the lungs. How often is time taken to discover these essential facts? The patient does not appreciate their importance, and unless the physician takes note of such conditions their possible significance does not occur to him until serious complicating symptoms arise.

Patients are more apt to tell of any surgical operations they have had, but accurate knowledge of what was done is often lacking. Yet the importance of knowing this accurately, especially when there were abdominal or pelvic procedures, no one can deny. A supposedly simple suspension of the uterus may have resulted in a fixation. The bad results that often come from this condition during labor are well known but all too frequently forgotten. A repair of the outlet must be known and recorded, for if not noted and a disaster occurs, the physician in charge might readily be blamed unreasonably for the result. Amputations of the cervix in the childbearing age have led in subsequent pregnancies to more than one ruptured uterus, and the proper management of such cases depends on a knowledge of the patient's past history.

The menstrual history is also important. All physicians ask for the date of the last catamenia, for from that the date of delivery is reckoned; but do many physicians inquire carefully into its characteristics? Was it on time; was it scanty; was it absolutely normal; has there been any show since this last period ceased? An irregular menstruation is oftentimes the first suggestion of an ectopic gestation, the diagnosis of which many times, you will agree, taxes the best skill we have. By an early diagnosis and operation the results are excellent; but if the diagnosis is delayed or missed the result is frequently death.

Again and again in taking a patient's past history one obtains an excellent idea of the woman's mental poise and her probable ability

to stand up under the strain of pregnancy. If there is real mental instability, the condition should be found out early and appropriate action taken.

All too frequently the character and results of previous pregnancies and labors are ignored. These facts must be carefully inquired into and properly evaluated. If anything abnormal or unusual is uncovered, it must be kept in mind during the entire pregnancy and labor. A patient who has had an operative delivery and a stillborn baby must be carefully watched and the proper procedure in the present pregnancy studiously determined.

Following the taking of the history, a complete physical examination must be made, yet in this many physicians fail utterly. Some may obtain a specimen of urine, others may add a blood pressure reading, but relatively few make any adequate physical examination. Every physician knows what this means, and it is entirely unnecessary to go into the details of such an examination at this time. But if it is not done, how can a physician give his patient proper care? Bad teeth must be removed or properly filled. There is no excuse in these days for the old saying, "For every child a tooth." If a cardiac condition is found it is only by careful estimation of the heart's ability to stand the added strain of pregnancy that we can determine whether it is safe for the pregnancy to continue. A tubercular condition needs careful study, and if an interruption of pregnancy is indicated for this cause, benefit will ensue only if it is done in the early weeks.

The condition of the kidneys is determined by blood pressure readings and urinalysis. If any pathological condition is discovered, further study must be made. It is through the study and treatment of these cases which are detected early that the greatest improvement in the management of toxemias of pregnancy has occurred. If by laboratory tests—the non-proteid nitrogen, the phenolphthalein and Mosenthal tests—it is shown that the patient has an early chronic nephritis, it becomes the duty of the physician to tell her the danger she runs in going on in the pregnancy and the unlikelihood of her being able to have a living

baby—surely not without definitely shortening her normal span of life.

A physical examination is essential early in every pregnancy to establish what the patient's condition is at that time. If that is not known, how can the deviations that are sure to come as pregnancy goes on be properly interpreted? As infrequent as such examinations are, abdominal and vaginal examinations are, I am afraid, even less frequent. Yet in most early cases how can the diagnosis of pregnancy be established without a vaginal examination? The position of the uterus and the condition of the pelvis are determined. A pelvic tumor is not so uncommon that any one of us can afford to ignore the possibility. A vaginal examination determines whether there is a pathological secretion, and if found a microscopic examination of a smear should be made, for the possibility of a gonorrheal infection must be kept in mind. If such an infection is found, proper treatment must, of course, be instituted at once.

A speculum examination is constantly omitted. To me, that is a most important part of the examination, for by it a marked erosion of the cervix, a possible polyp, or rarely an early cancer will be discovered. Whether or not pelvic measurements are taken at this first visit of the patient I think is immaterial. Personally, I do not do it at this time because there is so much to do the first time a patient presents herself for care. Blood for a Wassermann reaction should be taken, I am confident, from each patient. This is a routine in well-established clinics. It is, however, the exception among private physicians. Why this should be so I do not know. The procedure is not difficult and the patients do not resent it. The benefit that may come to the patient and her baby in case of a positive finding far outweighs any possible objection to it. Its general adoption must be insisted upon, for the welfare of the baby in such cases depends entirely upon early and active treatment.

The hemoglobin is seldom estimated, and yet how otherwise can the anemias of pregnancy be discovered early and properly treated? If the anemias are not discovered, the complications that arise following this condi-

tion in the puerperium are many times wrongly diagnosed and treated. A Wassermann and a hemoglobin estimate are both essential in every pregnancy.

How often does the doctor go into detail with the patient in regard to her diet, exercise, recreation and rest? Her general well-being must be supervised, and she must feel free to talk with her physician about the little things that come up in the course of her pregnancy in order that she will have a proper mental attitude to her pregnancy and to her labor.

As pregnancy goes on, the visits should be made regularly at least once a month for the first six months and then every three weeks, during the eighth month every two weeks, and the last month once every week or ten days, for it is by these routine visits that the health of the patient is insured. Any rise in blood pressure must be noted. A creeping up of the diastolic is a most important point to be observed. The significance of the gradual rise in blood pressure is often neglected. The urinary examination for albumin and sugar should be done before the patient leaves the office. If sugar is found, treatment must be instituted to overcome it, for if it is allowed to continue indigestion becomes marked and oftentimes an irritation of the introitus appears. If sugar in the urine is neglected it may be the beginning of a diabetic condition. For years I have demanded that my patients send to the office a specimen of urine between their visits.

There has been no great improvement in the treatment of eclampsia in the last few years. It is true, however, that the incidence of eclampsia in well-conducted obstetrical clinics has diminished. Why? Simply because these clinics insist that the patients return regularly for observation, and when untoward symptoms of headache, a rising blood pressure, or albumin in the urine are found, these patients are hospitalized. The incidence of toxic conditions in pregnancy has increased in obstetrical hospitals for this reason. Occasionally we do meet an overwhelming fulminating toxemia, but fortunately for us this is the exception, not the rule. The prodromal symptoms of eclampsia are cumulative, and by constant vigil,

frequent visits and an appreciation of the danger signals, maternal mortality from this condition can be lowered.

The weight must be carefully watched, for patients who gain excessively are much more likely to develop a toxemia than those whose gain is kept to a total of about twenty pounds. Incidentally, those patients who gain little usually have a much better type of labor than those whose weight increases rapidly.

At each visit abdominal palpation and measurement of the fundus should be carefully done and the findings recorded. Many times by this means a twin pregnancy is detected, or a breech presentation may be discovered and an external version can often be easily done at the appropriate date.

I do not believe it is necessary or even advisable to make a vaginal examination at each visit. But between the seventh and the eighth months a careful vaginal examination should be made to determine the relation of the size of the baby to the pelvis. It is at this time that I usually measure the pelvis. The external measurements are only suggestive. Rarely we find an actual contraction of the pelvis. Emphasis must not be placed on the pelvic measurements alone. The important point is to determine the size of the baby that must come through the given pelvis, and it is by repeated abdominal examinations and an occasional vaginal examination that one settles whether or not the presenting part is entering the brim.

By the eighth month, a physician who has followed his case carefully has in most cases a good idea whether that pelvis will pass the given baby without undue difficulty. The question of whether or not the biparietal is through the brim seems to cause a great deal of difficulty to many men. Again and again I have seen cases in consultation where there was a question of disproportion, and I have been told that the head was overriding, although on careful examination I found that it was not. By abdominal palpation it is not difficult to determine whether the head has settled into the pelvis or not. If it has settled down, one comes onto the occipital part and it is impossible to move the head from side to side.

On the other hand, if the head is not in the pelvis, when it is taken between the hands it can be readily moved and there is no true engagement. This can be readily checked by a vaginal examination. If there is any real overriding, with two fingers making the examination the thumb is swept up over the symphysis and this overriding is easily felt.

If the presenting part settles well down into the pelvis, it is evident that the inlet is large enough for the given baby, and the question of the outlet arises. Is the outlet large enough? That is a measurement that is important, frequently neglected and oftentimes poorly made. The simple little outlet pelvimeter of Williams is most satisfactory for this purpose, but if one has not that pelvimeter he knows, or should know, the size of his closed fist, and by rocking the first between the ischia the size of the outlet is readily determined. The determination of the size of the outlet is important, for if it is markedly contracted, as it frequently is, the difficulty in the delivery will be great, damage to the mother severe, and the baby seriously injured or lost.

By the last month of pregnancy the physician should make up his mind as to the probable method of delivery. If the head is found well in the pelvis and the outlet is not contracted, it may be definitely stated that the patient in all probability may look forward to a normal labor. No one can prognosticate what type of labor it will be and how readily the cervix will dilate.

If on the other hand the presenting part in a primigravida remains high, freely movable above the brim, whether or not there is true overriding, the possibility of an abdominal delivery must be kept in mind and the patient carefully watched from the beginning of her labor. With the knowledge that with the majority of primigravidae the head is in the pelvis at least a week before delivery takes place, there should be no excuse for a doctor to allow a patient to go on in desultory labor for hours, possibly days, and then expect a good result from an abdominal delivery. The days of such neglect should be past. I regret to say, however, that apparently they are not. We are constantly hearing of cases that are allowed

to go on in labor without progress for many hours and when the physician in charge asks that a Cesarean be done he often expresses surprise that a careful, thoughtful obstetrician refuses to operate.

If as term approaches the presenting part in a primigravida does not enter the pelvis, and if there is doubt whether it will enter, in many instances the patient should be fully etherized and the pelvis carefully examined. With firm pressure at the fundus and over the occiput, if there is no disproportion, the presenting part may be pushed down into the pelvis to the lower border of the symphysis, showing that the inlet is not contracted. It should be unnecessary to add that this examination must be done under strict aseptic precautions. In some communities x-ray procedures which are now used in many clinics are available to aid in determining the size of the baby and the pelvis. In all cases where a Cesarean section is to be done, an x-ray should be taken to rule out gross deformities.

The point to be remembered and driven home is that the conscientious physician can determine in most cases before labor starts the method of delivery which will involve the least risk to mother and baby. Were this done in each case, the number of emergency Cesareans would be cut tremendously. Occasionally even the careful physician will do a Cesarean as an emergency, but it should be the exception and not a frequent happening.

Normally, a pregnant woman does not bleed by vagina. Yet there seems to be throughout the country an absolute disregard of the fact that any such bleeding is a danger signal. In the earlier months irregular bleeding may mean a miscarriage, a pathological condition of the cervix, or a possible extrauterine. If the first sign of bleeding is not thoroughly investigated and properly interpreted, the patient's welfare is jeopardized. Whether or not an ectopic pregnancy is accompanied by severe pain depends entirely upon the pathological condition of the tube, but practically every extrauterine shows some variation from a normal menstruation.

As the patient progresses in her pregnancy, the appearance of bleeding should suggest a

placenta praevia until it is definitely proved otherwise. If we are to improve our maternal mortality in bleeding cases, the majority of them must be taken to hospitals where resources are available to combat a possible hemorrhage. Donors must be in readiness for a possible transfusion and with this in mind it is the duty of the physician to send to the hospital with the patient relatives whose blood should be immediately grouped and matched. Preparedness is the only way to meet these conditions. The practice of making a vaginal examination on a bleeding case with no means at hand to combat the frightful hemorrhage which may occur is common and must be discarded if we are to lower our maternal mortality from this cause.

The vaginal examination that is made between the seventh and eighth months will in most cases rule out a praevia, because the examining fingers come at once onto the thinned lower uterine segment with the presenting part immediately beyond. It will not, however, rule out a low attached placenta. A separated placenta is an emergency. It may show no bleeding by vagina. In most cases the characteristic symptoms of pain and a board-like uterus are present. Unless the physician has this condition in mind he frequently misses the diagnosis, may think the patient is going into labor, and does not institute proper treatment. He does not become apprehensive that anything is going wrong until bleeding appears, when in many cases the damage to the patient has become so great that any operative procedure leads to death. Bleeding cases call for immediate action. Delay of even a few hours may mean the difference between life and death. The proper management of these cases is another problem into which we have no time to enter today.

These, then, are some of the important points in prenatal care. I am confident that if all women had standardized care such as I have outlined, the maternal mortality would be markedly lowered. With our present knowledge prenatal care will not prevent the toxemias of pregnancy; it will, however, materially lower the incidence of eclampsia. This is shown by the fact that eclampsia in all well-

managed obstetrical clinics has decreased, but in cases where convulsions have occurred the maternal mortality has remained about the same. A rise in blood pressure, the appearance of albumin in the urine, oedema of the face or hands or sudden gain in weight must all be promptly and correctly interpreted if we are to safeguard the patient. Prenatal care will not lower the incidence of bleeding cases; it has absolutely no influence on the accidents of pregnancy. The mortality may be lowered, however, by giving these cases intelligent care when they do occur.

It is often impossible in rural districts for the physician to see his patients as often as necessary, and in such cases the well-trained public health nurse, carefully supervised, can be of tremendous help. Visiting nurses have aided greatly in the follow-up of clinic cases and in those cases which can not go to doctors as often as is advisable. They could greatly increase their splendid work were the physicians more broad-minded.

Patients with a serious cardiac or nephritic condition obviously run a much greater risk in attempting to go through a pregnancy than those patients who have normal heart and kidneys, and it is not strange that the maternal mortality rate in these conditions is high when there is no adequate care. To improve the maternal mortality in this group the patients must have constant medical supervision and expert obstetrical care.

It is obvious that I can not go into each of the complicating diseases that may occur with a pregnancy. Each one must be carefully studied in its effects on the pregnancy and the effect of the pregnancy on the complication. It is, however, fair to state that when surgical procedures have to be performed it is better judgment to operate if the necessity arises rather than to wait until the pregnancy is over.

I feel strongly that intelligent supervision during pregnancy has a real bearing on the incidence of septicemia as a cause of maternal mortality. With patients who are carefully studied and who it is known may have a difficult labor, plans are made beforehand for the proper method of delivery. When a patient is first seen exhausted after many hours of

labor, some ill-advised abdominal delivery is often attempted. Not only does sepsis often follow an abdominal delivery in such cases, but it also frequently follows a hard operative delivery. The mortality rate from sepsis has not dropped in the past few years to any appreciable extent. It is true that the problem of abortions, which account for possibly one-quarter of our septic deaths, is a factor that must be considered whenever we speak of maternal mortality, but that is another problem which of course we can not touch today.

Fortunately, the great majority of deliveries are practically normal, yet even in these cases the incidence of sepsis is greater than it should be. This, I am confident, can be lowered if all patients have adequate supervision before delivery, for as I have already said the difficult cases would be found out before labor starts and a definite method of delivery mapped out. For with good medical supervision before labor starts, the necessity for frequent vaginal examinations is eliminated, and abdominal palpation and rectal examinations are substituted.

The greatest defect, I believe, in prenatal care at the present time is not that the doctors do not know what is right; it is that they do not use their best judgment in carrying out the standards which are now well established and which are in effect in all well-conducted clinics. Medical education in obstetrics is inadequate in many schools, but more often it is not lack of knowledge but lack of an obstetric conscience on the part of the physician which brings disaster to the patient. Such men are a danger in any community. May not this be a part of the reason why, aside from the lessening of incomes due to the depression, many patients elect to go to well-managed clinics rather than to stay with some private doctors? They realize that the results may be better.

A further reason for unsatisfactory prenatal care is that the rank and file of patients have not been educated to the necessity for seeking such care early. In this education the medical profession must lead. Every possible effort must be made to overcome the gross ignorance and carelessness that exists among a large

group of patients. There must be constant reiteration that prenatal care is essential, and that maternal mortality can only be lowered when every woman has adequate medical care during her entire pregnancy.

In regard to infant mortality, prenatal care will not prevent congenital malformations and the deaths that follow; it can have no influence on these at all. Neither will it prevent all premature labors, although it will control some. It should bring the incidence of syphilitic babies down to a minimum, and in that way decrease the infant mortality somewhat. Infant mortality will unquestionably be lowered if the cases are carefully studied and the proper method of delivery carried out in each case.

Although I am asked to speak on prenatal care, I can not help saying a few words about the importance of adequate delivery care, for the two must go hand in hand if we are to have good results. Prenatal care alone will not materially help us in our effort to lower maternal mortality. No matter how good this may be, it will all be wasted without good care at delivery. This of course means that for complicated, difficult cases we must have well-equipped maternity hospitals staffed by physicians skilled in obstetrics. Prenatal clinics, unless closely linked with hospitals, fail to give complete service to the patients. Prenatal care must not be thought of as something apart. It is simply one small but important division of the complete care of the pregnant woman. Prenatal care, delivery care, postpartum care—they can not be separated—to be of real service to a community all must be adequate.

Until the medical profession does its share in bringing this about, we shall have no real improvement in our mortality rates. We are often unjustly blamed for the published statistics. It is true that were the conditions ideal, many of the deaths which occur could be prevented, but even under conditions far from ideal the results should be better than they are. The studies that have been made on maternal deaths have shown that there are many which are preventable. Some must be scored up to the patients themselves, but for some the phy-

sicians must bear the criticism. These we must seek to eliminate entirely, and the first step, I am sure, is the insistence that every woman have adequate prenatal care.

To accomplish the best results the community must work together. The general public, the patients, the hospitals and the physicians must be united in a common desire to see that preventable deaths do not occur. When the economic status of the patient is such that she must be aided through this crisis in her life,

the community must see to it that such aid is given.

The privilege and the duty of leadership in this matter lies with the physicians. Where just criticism can be made, they should be the first to make it. Unless we accept this responsibility and take the lead in cutting down these preventable deaths in obstetrics, an aroused public opinion will eventually take the matter out of our hands entirely, and what this may lead to no one of us can truly say.

DISCUSSION

Dr. Samuel A. Cosgrove (Jersey City): Dr. DeNormandie has given us one of those rare papers which says every thing which any of us might have wished to say on his subject, and has said it clearly and well.

He has invited me to tear it to pieces. It were as easy to tear apart the pyramids, so broad is its base of sound common sense and so thoroughly does its structure represent fine ideals of honest craftsmanship. Its very simplicity makes it a sharp challenge to every one of us.

The statement has elsewhere been made, that the increased emphasis on prenatal care during the last two decades should have shown greater results in reduction of maternal mortality than has been apparent, were that care really as great a contribution to that end as we have hoped and believed it to be.

Dr. DeNormandie has adequately answered that thought by pointing out that only a small percentage of women do actually receive really good prenatal care. But he states his conviction that if they *did* receive such care, it *would* result in very marked reduction of maternal and infant mortality. He does not justify his conviction by statistics, but by outlining what *good* prenatal care is.

Such care is wholly within the power of any physician to afford his patients. There is not a single detail of the Doctor's outline which is bizarre, unreasonable or difficult. But I wonder how many, even of us who pretend to special interest in obstetrics, might honestly claim 100 per cent efficiency on the basis of it!

Yet patients have a right to look for such efficiency on the part of any doctor to whom they submit themselves. Dr. DeNormandie is perfectly right in saying that they do not get it. That is our fault. That fault we can and must correct in relation to all who come to us seeking service.

How about those who, through ignorance, or apathy, or poverty, do not seek our service? We must expend every bit of effort of which we are capable in overcoming these bars on the part of the public to the universal benefit of prenatal care. Until we have done so, we have not fulfilled our duty and responsibility.

To provide good prenatal care for all women, the Doctor wisely stressed the necessity for the integrated coöperation of many agencies. In this teamwork we doctors, as individuals and as organized groups, must lead, if we can.

But to obtain and maintain this leadership, we cannot stand critically aloof. We must join heartily in all sincere efforts toward the common goal, even though we may not always thoroughly approve leadership and methods. This we have not always, nor even generally, done. It is significant that the Doctor's reference to the inauguration of organized prenatal care in this country ascribed it to two *lay* organizations. Upon lay organizations has rested the initiative and burden of most of the progress since made in the movement.

In some instances, it is true, groups of doctors have themselves accomplished much. The organization and work of the Essex County Maternal Welfare Commission represents unique and in high degree successful achievement. Bergen County has made a splendid beginning. But success is not nearly complete. There is a long, long way to go yet before our work is fully accomplished, and we are not able to carry on unaided. We need, and must have, all the help which lay organizations and governmental agencies can give us, to reach our final goal. We are not in and of ourselves strong or numerous or rich enough to accomplish it alone everywhere.

So we must welcome non-professional activities to help womankind. We must join in, and coöperate with such activities, not disdain nor discredit them. Let us be honest in maintaining each one his own standard of service; let us brush aside unworthy considerations of personal advantage and jealousy; let us meet the challenge of Dr. DeNormandie by frankly accepting the primary responsibility for "thing-not-as-they-ought-to-be"; let us apply ourselves to sincere coöperation in *all* good effort making for safe maternity; let us do this, not in fear of what the dominance of public opinion may lead to, but in satisfaction of the demands of that obstetric conscience to which the Doctor has alluded. Then will recognition of our leadership be gladly acknowledged; then will the direction of the work automatically be ours!

THE ACUTE SURGICAL ABDOMEN

By G. BLACKBURNE, M.D., Newark, N. J.

Presented at the Academy of Medicine of Northern New Jersey before the Italian-American Medical Society of New Jersey, June, 1934.

In assembling the data for the preparation of this paper I want to acknowledge recourse to all of the facilities offered by the Academy of Medicine of Northern New Jersey, which I will supplement with my own experience of twenty-seven years in the practice of surgery. I was surprised at some of the things which I found in this review, and when I come to name the various conditions which may give acute abdominal symptoms, I think you will agree with me that one must be extremely alert if he is going to make a reasonable accurate diagnosis in a series of acute abdominal cases. The most common acute abdominal conditions met with in order of frequency are: acute appendicitis, perforated intestinal ulcer, and intestinal obstruction. Often times it is quite sufficient to say that this is an acute surgical abdomen, and such patients should be operated upon, using a wide incision and recognizing and attending to any pathology which may be encountered. However, it is much more scientific, and safer for the patient, if we can determine in advance, what we expect to find and what we wish to accomplish at the operation. In acute appendicitis, perforating duodenal ulcer, intestinal obstruction and many less common conditions, every hour of delay diminishes the patient's chance of recovery.

Storez gives a synopsis of 4,418 cases of acute surgical abdomens over a five-year period. Of these, 3,316 were appendicitis, 423 cholecystitis, 432 salpingitis, 119 ectopics, 115 strangulated hernias, 138 intestinal obstruction (caused by other factors than hernias) and 34 diseases of the pancreas.

Horgan reports 319 acute abdominal cases in children in which there were 236 cases of appendicitis, 22 of hypertrophic pyloric stenosis, 18 of intussusception, 12 intestinal obstruction, 8 abdominal tumor, 6 tubercular peritonitis, 2 abdominal injury and 2 cases of foreign bodies. It is clear from the above that our line of reasoning, if the patient be a

child, must be modified somewhat from that in the adult.

Regnier maintains that every case with sudden severe abdominal pain, tenderness and rigidity warrants hospitalization and immediate operation, after ruling out a few of the outstanding conditions which may simulate an acute surgical abdomen. A low enema may be permitted in such cases, but cathartics are absolutely contra-indicated.

Among the non-surgical conditions, or conditions not necessitating immediate surgery, which may give acute abdominal symptoms must be mentioned pneumonia, pleurisy, angina pectoris, vertebral disease, diabetic pain, gastric crisis of tabes, gastro enteritis, cholecystitis, perinephritic abscess, pyelonephritis, ureteral kinks, stricture and calculi, diseases of the male and female adnexa, tumors of the kidney, influenza, lead poisoning, the painful type of nephritis, intestinal parasites, and foreign bodies swallowed and in the gastro-intestinal tract or accidentally left at a previous operation.

Among the conditions requiring prompt surgical intervention are acute appendicitis, ruptured duodenal ulcer, intestinal obstruction from any cause, tuberculosis of the ileo-cecal region with perforation, empyema or rupture of the gall-bladder, acute diverticulitis, pancreatitis, ectopic pregnancy, obstructed or strangulated herniae, perigastric or subphrenic abscess, abscess of the liver, rupture of an aneurysm, particularly of the splenic artery, carcinoma of any part of the alimentary tract, tubercular peritonitis, torsion of the omentum, ovarian cyst or other tumors with twisted pedicle, trauma, with rupture of the bladder or other visceral damage, and penetrating wounds. These conditions, as a rule, require immediate laparotomy, and if in doubt it is much better to operate than to delay. The few unnecessary operations would be more than

compensated for by the many cases that would be saved.

I make it a rule to go over the chest and have a white blood count, differential, and a urine analysis, with particular attention to the microscopic findings, in all acute cases. By these methods beginning pneumonia and pleurisy may be reasonably excluded, particularly if the pulse-respiration ratio is not distorted. Often by merely palpating the apex beat and noting the respiration rate at the same time, a disproportion from the normal 4-1 ratio will lend a clue which will cause a more thorough chest examination. In this connection I always remember my preceptor, Dr. Winthrop D. Mitchell, who one day returned from an absence of several weeks and walked through the surgical wards of St. Michael's Hospital, making several very accurate diagnoses by merely glancing at the patient whom he had never seen before. After all, clinical experience means a great deal in diagnosis.

Vertebral disease of the dorsal or lumbar spine may be complicated by a psoas abscess, and these abscesses have been known to open into the bowel, bladder or even into the peritoneal cavity. Spinal kyphosis or muscular rigidity in the dorso lumbar region should furnish a cue in such cases.

Cases with gastric crisis of tabes are very frequently sent in with a diagnosis of ruptured duodenal ulcer or acute appendicitis, and a check of the pupil for its reaction to light is a very simple and quick method of ruling out this cause. It should be particularly suspected as a cause in acute abdominal cases past middle life. The argument may be advanced that tabetics may also have acute surgical conditions in the abdomen, but I believe that many unnecessary laparotomies can be avoided by a momentary check up on the pupil.

Cases of acute gastro enteritis and ptomaine poisoning will usually show marked vomiting and diarrhoea, while diarrhoea is the exception in other acute surgical abdominal conditions.

Cases of acute cholecystitis generally give a history of previous attacks or digestive disturbance for some time. It is more common in stout individuals past 40. Pain is present in the epigastrium and upper right quadrant and is

generally accompanied by vomiting. The temperature is 101-103 and there is tenderness over the gall-bladder or epigastrium. These cases may have morphine after the diagnosis is established. The treatment of acute cholecystitis may be open to discussion as to whether it constitutes a surgical emergency or not. In my opinion it, as a rule, is not, and I feel certain that my surgical mortality has been diminished by treating these cases expectantly for several hours or even days, by withholding all food and fluids by mouth and supplying water and glucose by vein or rectum. During this period a duodenal tube may be used and an attempt made to aspirate some bile for analysis. A serious case can thereby often be carried over a critical stage and operated upon, if necessary, at a later date. Of course a case of empyema or rupture of the gall-bladder calls for prompt surgical intervention.

A perinephritic abscess on the right side may simulate a retrocecal appendix, but in these cases as well as in pyelonephritis there is usually pain and tenderness in the costo vertebral angle. Reaves points out that in urological conditions chills are more frequent and the temperature higher than in intra-abdominal lesions. Also nausea and vomiting are uncommon. Ureteral kinks, stricture and calculi and the painful type of chronic nephritis will often simulate appendicitis and in these cases, in particular, a carefully examined catheterized specimen of urine from a woman, or the second of a two-glass specimen from a man will materially help in the diagnosis. Tumors of the kidney do not generally give pain, or any sudden onset of symptoms which need discussion here.

Diseases of the male and female adnexa will often, at first glance, give symptoms simulating an acute surgical abdomen, but a check-up for urethritis or epididymitis in the male and a vaginal or rectal examination in the female will quickly sort out this type of case.

Influenza often gives symptoms simulating acute appendicitis, and in these cases I have found that the white blood count, showing a low total with a relative lymphocytosis is one of our best diagnostic aids. If such cases are operated upon, through error in diagnosis, they

are very prone to be complicated by pneumonia, pleurisy and empyema.

Lead poisoning, with colic, is not very common today, but it must be remembered as being capable of giving violent abdominal symptoms. Cases occur generally in painters and are recognized by the blue line along the border of the gums.

Intestinal parasites cause an eosinophilia, and here again the differential white blood count helps us to recognize these cases.

Foreign bodies, which are swallowed and reach the stomach, can as a rule pass through the remainder of the alimentary tract, but such cases should be followed by careful observation and frequent x-ray check-ups. The main danger is that of necrosis of the wall of the bowel in the region of the ileo-cecal valve due to a prolonged pressure in this area. In the case of sponges or instruments, accidentally left in the abdomen at a previous operation and found by another operator, I think it appropriate to quote Thorek, who repeats the verse "Let him who is without sin among you cast the first stone."

I will now take up the conditions which require prompt surgical intervention. Acute appendicitis stands at the head of the list as the most common surgical emergency. It may seem ridiculous to repeat the classical symptoms of generalized pain, shifting in 4-6 hours to the R. iliac fossae, nausea, vomiting, rise of temperature, rigidity and marked pain over McBurney's point, but this paper would not be complete without it. Such cases, if operated upon in the first 24 hours by a surgeon of ordinary ability will practically all recover. Delay in these cases invites perforation, peritonitis and probable disaster, because we cannot visualize with any degree of certainty exactly what is going on. Delay in diagnosing and operating on these cases exacts a mortality which has been quoted as high as 20 per cent in this country. Purgatives, delay in seeking advice or in making a diagnosis, and a tendency to do too much at the operation are all factors contributing to this staggering figure.

Ruptured duodenal ulcer is a fairly common occurrence and, unless it be a slow leak, will give the following symptoms: A patient with

a history of digestive disturbance will have sudden agonizing epigastric pain and show signs of shock. The pulse is rapid and weak. There is no immediate rise of temperature. A typical board-like rigidity of the abdomen occurs, which is not seen in any other condition. The mortality in these cases depends entirely upon the interval between the accident and surgical intervention.

Acute intestinal obstruction gives the highest mortality of any acute abdominal condition (40-60 per cent). Strangulated hernia is the most common cause. Post-operative adhesions come next. Internal hernias must be borne in mind. Intussusception as a cause occurs in infants and young children, while in later life volvulus and carcinoma of the bowel must be considered. I operated in the past month on the first volvulus case I have seen in 25 years and I do not consider the condition as very common. Malignancy is a fairly common cause of obstruction in later life and mesenteric thrombosis must be considered in cases with cardiac valvular disease. The symptoms of intestinal obstruction are paroxysmal pain, nausea, vomiting and later distention, toxemia, weak pulse and prostration. The vomiting may progress from stomach contents to fecal material. The stethoscope is a valuable aid in the diagnosis of these cases, as rumbling may be heard in the abdomen accompanying the pain, as the peristaltic waves hit the obstruction. These cases do not show any local rigidity and are among the most serious emergencies with which we have to deal.

Tuberculosis of the ileo-cecal region, with perforation of the bowel, is seldom diagnosed as such before operation, the cases being generally diagnosed as acute appendicitis. I can look back on several such cases and the prognosis is usually very grave.

Acute pancreatitis can seldom be diagnosed with any great degree of certainty. The symptoms are very similar to those of a ruptured duodenal ulcer but the pain is more to the left of the mid-line. There is vomiting and collapse and there may be a swelling in the epigastrium which has a doughy feel, not the board-like rigidity of a ruptured ulcer. Prompt operation, with drainage of the gall-bladder

and the lesser cavity saves a small proportion of these cases, which are usually opened before the diagnosis is made. I have operated upon two recently; one of them, correctly diagnosed by Dr. William Petry, survived.

Ruptured ectopic and tubal abortion cases are not as a rule difficult to diagnose. The history of skipped periods, sudden lower abdominal pain, air hunger and shock is typical in these cases. If in doubt, a cul de sac puncture may be made before laparotomy is performed.

Rupture of an intra-abdominal aneurysm, particularly of the splenic artery, gives symptoms very similar to those of an ectopic, minus the history of pregnancy. This, of course, calls for immediate operation.

Torsion of the great omentum must be remembered as one of the causes of acute abdominal crises. Hernia is said to be present in most cases and as a rule there are adhesions to the sac. I have never encountered a case.

Trauma is more common today because of our rapid means of transportation. Jaki points out that in suspicious intra-abdominal injury there are three stages of symptoms: first, shock; second, improvement; third, signs of internal hemorrhage or peritonitis. Shock persisting over three hours after injury suggests perforation of a hollow viscus or rupture of a solid one. Conservatism and careful watching are the best rules for the first few hours. Dr. Teeter called to my attention, several years ago, that a frequent hemoglobin estimation was very valuable in looking for concealed hemorrhage. In fractures of the pelvis it is important to look for bladder injury. The bladder may be ruptured intra- or extraperitoneally. If intraperitoneally, the condition is most urgent and calls for rapid surgery with drainage and repair. In these cases the catheter fails to show any urine, while in the extraperitoneal cases it may show a little bloody urine. It is permissible to instill a few ounces of sterile water in these cases and measure the return. Rupture of the kidney may follow severe trauma to the loin. There is severe shock and bloody urine will be found on catheteriz-

ing. Prompt surgery is imperative, keeping retroperitoneal, if possible.

In cases of bullet or stab wounds of the abdomen, there is a trend towards conservatism in recent reports. In perforation of any part of the gastro-intestinal tract an x-ray picture taken in the upright position will show an air bubble under the diaphragm. This method may be also used in diagnosing cases of perforated ulcer. Guerry advises not to be in too much haste to operate. First combat the shock and, if necessary, do a blood transfusion before opening the abdomen. The mortality of stab wounds in civil life is given by Billings and Walking as 25 per cent, and of gunshot at 39 per cent.

Delay in diagnosing and operating upon strictly surgical abdominal cases exacts a high toll of life, and the laity must be educated to the point of considering any acute pain in the abdomen as a danger signal which should warrant consultation with his physician. Morphine is particularly to be condemned before a satisfactory diagnosis is arrived at, as it gives the patient relief and a false sense of security. Cathartics are often responsible for converting an otherwise simple case into a serious and complicated one.

As previously stated, if in doubt as to an abdominal condition, it is much safer to operate than to delay. And if operation is done, make a free incision, as much more harm may be done while working through a small one and the real pathology may be overlooked. In desperate, neglected, acute cases, do as little as possible to relieve the condition; do not make a prolonged search for the appendix if an abscess is found; do not attempt a resection when a colostomy or ileostomy will suffice for the time, and tide the patient over a critical stage. Too much surgery is often worse than no surgery at all, and if we are going to reduce our mortality in acute abdominal surgery, we must start by educating the laity, be keen in our diagnosis, taking advantage of the laboratory and x-ray, and be prompt to operate when the occasion warrants.

PRESENT-DAY METHODS OF TREATING THE MENTALLY SICK

By J. BERKELEY GORDON, M.D.,

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An address to the Aesculapian Club of Jersey City

The fact that New Jersey has over 17,000 mentally sick people in its state and county institutions for the insane, feeble-minded, and epileptic, with an annual budget of approximately \$7,000,000, is, perhaps, sufficient justification for a brief review of the present trends in treatment of this class of patients. The population of our public mental institutions seems to vary inversely with the economic barometer, rising in periods of depression and falling off in times of prosperity. We may, therefore, by inference, draw some consolation from the recent drop in our admission rates. In addition to those kept in state and county institutions there is an unknown number cared for in private sanitariums, nursing homes, etc. This population tends to vary directly with the economic index. What is being done to restore these casualties to productive life and useful citizenship? Only the briefest and barest sketch of treatment methods will be attempted in this paper.

PROPHYLAXIS

Consistent with the usual concept of treatment, we begin with prophylaxis. A great deal can be done in the prevention of mental illness through an adequate mental hygiene program. All three of our state mental hospitals operate mental hygiene clinics, serving numerous communities in the northern, central, and southern parts of the state. Into these clinics are brought all types and degrees of mentally sick people, from the school room discipline problem child to the frankly psychotic adult. Oftentimes these people can be kept out of institutions and preserved for useful citizenship by explaining to them and their families the psychogenic factors operating in the situation; and through careful physical examination, finding out the somatic pathology contributing to depression, ill health, and mental retardation. Such cases are then referred to

their family physician with recommendations for corrective therapy.

FOCAL INFECTIONS

Focal infection undoubtedly plays a part in the production of the psychoses. Whether we are willing to say that the toxemia of an infection is the primary cause of psychosis or is merely a precipitating or predisposing cause in an inadequate or ill-adjusted mental mechanism is not of vital importance. We do believe that all mental patients should be given the advantage of a complete history and physical examination, including laboratory tests; and that they should be put in the optimum of physical condition by the removal of whatever pathology can be discovered and remedied. Such sources of infection as diseased teeth, tonsils, nasal accessory sinuses, the cervix, tubes, ovaries, prostate, seminal vesicles, gall-bladder, appendix, partial intestinal obstruction with chronic stasis, and absorption of putrefactive end products from protein splitting, etc., undoubtedly contribute to a low degree of physical resistance, mental retardation, and depression, and an inability to handle life's problems and disappointments in a normal way. Such infection, therefore, is a predisposing factor to mental illness in the victim, because he is unable to meet life's problems with the buoyancy of a normal healthy person who is possessed of a greater vitality and more detachment of viewpoint.

In the work of defocalization not only is surgery employed but such conservative therapy as colonic irrigations, vaccines, immune sera, castor oil therapy, and physiotherapy, in attempting to remove infection or build immunity against the infection where for some reason surgery is contraindicated. We have found that a surprising number of our patients are infested with intestinal parasites; and we now include a stool examination as part of our routine study on their admission.

CHANGE OF ENVIRONMENT

One of the most important things which an institution does for the mentally sick patient is to change his environment—to remove him from a situation which has become so intolerable that it has caused him to retreat from reality into a psychosis. When such a patient is taken out of the disturbing environment of home and business, with its attendant domestic, financial, and other worries, and placed in the quiet, orderly routine of a mental hospital, a great many of his imaginary problems solve themselves. He regains his perspective, and after having been given a physiological rest for the overburdened parts of his psyche, he is again able to take up his life problems in a normal way.

OCCUPATIONAL THERAPY

Occupational therapy is employed in all mental hospitals. It may consist simply in the housekeeping work of cleaning up the wards and making the beds, or in the more laborious work of running the farm, orchard, dairy and truck garden; or it may be the more formal and frankly therapeutic work of occupational therapy shops where patients are carefully selected and given such manual work as is compatible with their mental organization, their previous experience, interests, and skill. In addition to giving patients a useful occupation upon which their attention may be centered, preventing further introversion and descent into the fantasy life, occupational therapy is a very real assistance in the economics of a mental hospital, inasmuch as a great deal of useful sewing, mending, and repairing can be done by the women inmates, and farm, dairy, landscaping and other work can be done by the men patients. Coincidental with the psychotherapy thus accomplished, there is usually an accompanying improvement in the physical well being, especially in those occupations which may be employed outdoors in the fresh air and sunshine.

SPECIAL TREATMENTS

Hydrotherapy is useful especially for the new mental patient who is in an acute phase of illness. The extremely confused, resistive,

disturbed, and violent patient can be greatly helped by the sedation afforded by continuous baths, hot or cold wet packs, and colonic irrigations. In addition to the hyperactive type, for whom sedation is indicated, the patients at the opposite end of the scale, such as the stuporous catatonic, can be helped by stimulative hydrotherapy with the Scotch douche, needle shower, and the salt glow, etc.

It is quite likely that there is some endocrine dyscrasia of varying degree associated with most mental sickness. This may vary from a very slight involvement to the obvious cretin. Endocrine therapy has proved helpful in many cases, especially those characterized by a deficiency of essential hormones and secretions which can be supplied in adequate amounts by feeding the purified or dried gland products.

Pyrotherapy has been one of the hopeful advances in the treatment of paresis, tabes, and cerebrospinal syphilis, and of late years has been employed also in the functional psychoses. Drs. Stone and Spradley of the New Jersey State Hospital at Trenton in a recent communication have stressed the use of fever therapy in the functional psychoses. Pyrotherapy may be induced in a number of different methods such as the intravenous injection of triple typhoid vaccine, the inoculation with benign tertian malaria or with sodoku (rat-bite fever), the use of diathermy, and the use of radio waves without electrodes touching the body. All these are well-known methods of raising body temperature. More recently, such developments as the electric blanket and the electric bake ovens of various designs have been used. It would seem that the new metabolic accelerator, alpha dinitrophenol, which raises body temperature through increasing the metabolic rate, may have a place in this scheme and may prove a useful adjunct in the field of pyrotherapy. This awaits further investigation.

PSYCHOTHERAPY

As Dr. Leland Hinsie has so aptly pointed out in his recent book, "The Treatment of Schizophrenia", patients for psychotherapy and psychoanalytical work must be very care-

fully selected in order that the examinations should be successful or even justifiable. In order to profitably invest the time of a physician in such work, the patients must be capable of coöperating, of producing their psychotic material in language form, and of working in rapport with the operator. The incipient schizophrenic as well as the psychoneurotic can often be reached through the psychanalytical approach. By bringing into the cold light of day the psychic traumata which have been repressed, these ghosts can oftentimes be laid and the mental disturbance caused to disappear. In addition to the formal psychoanalytical work, psychotherapy is employed through encouragement, suggestion, example, and reëducation through attendants and student groups. It is our custom every summer to employ a group of medical or psychological students in this program. In some institutions hypnosis is included under this general classification and represents one of their regular means of approaching certain types of mentally ill. Reëducation through suggestion while in the hypnotic state has been found sufficiently effective to warrant its continuation.

DRUGS

The pharmacology of the mentally sick patient is varied and disappointing. As in somatic disease where there is a multiplicity of remedies for one ailment, usually none of them are effective. Our attack on this problem through drugs is hampered by our ignorance of cell chemistry and the nature of the thought impulse. Hence our efforts under this classification have been empirical and characterized by the very inefficient method of trial and error. We have found a few drugs which seem to help in some cases. That is about as far as we dare commit ourselves under this heading. For the manic patients, sedatives in the form of bromides, hydrated chloral, paraldehyde, luminal and sodium amytal are useful in a symptomatic way. For the retarded and depressed, large doses of caffeine seem to increase the permeability of the cell membranes and permit thought to flow with increasing fa-

cility. In an analagous manner, oxygen has recently been used in the stuporous, catatonic patients with apparently good results. By means of the oxygen chamber, in which the concentration of oxygen can be raised to approximately 50 per cent and the respiratory rate raised to 30 or more per minute by means of 5 to 10 per cent of carbon dioxide in the mixture, we can secure pulmonary hyper-ventilation with an increase of oxygen in the blood and an increased transmissibility for thought in these retarded minds. This improvement in some cases appears to be lasting. Zondek in Germany has advocated the partial replacement of the body's chloride ions by bromine in the depression psychoses. In such retarded and melancholy patients as the manic depressive-depressed, and the involutional states, he states that a replacement of chlorine by bromine through the administration of large doses of elemental bromine is effective in relieving depression and increasing alertness. Our own efforts with bromine therapy have been disappointing, but it is possible that this drug may yield results with persistence.

Profound and prolonged narcosis through sodium amytal, narcocine, somnifen, and cannabis indica has been tried, and in a few patients appears to yield good results. This type of therapy is characterized by a mortality rate of 4 to 5 per cent, and it is necessary to select patients rather carefully.

To mention a few other procedures: There is the production of an artificial leucytosis through the injection of nucleic acid preparations, the intravenous infusion of saline solution, the injection of metal salts, and the production of an aseptic meningitis through the intraspinal administration of horse serum.

In this brief and hasty review of the present status of therapy for the psychotic patient, a great deal has been frankly omitted and the remainder merely sketched in barest outline. Probably the truest thing that can be said at such a discussion is that we know little about its scientific basis, and that further advances will be dependent on the increasing knowledge of cell chemistry, the nature of the nerve impulse, and the phenomenon known as thought.

STATE SOCIETY ACTIVITIES

THE CONFERENCE OF STATE SECRETARIES AND EDITORS

The Conference of Secretaries and Editors of the State Medical Societies called annually by the American Medical Association was held on Friday and Saturday, September 21 and 22, 1934, in the Palmer House, Chicago, Illinois. About 80 Secretaries and Editors were present, their necessary expenses being paid by the American Medical Association. Those from New Jersey were Dr. LeRoy A. Wilkes, Executive Secretary, and Dr. Frank Overton, Editor of The Journal. Dr. Wilkes was on the formal program of the Conference.

The purpose of the conference was twofold.

1. To enable the delegates to become acquainted with the heads of the divisions and bureaus of the American Medical Association, and to hear accounts of their work first hand.

2. To exchange data and plans of action with one another and to learn how the societies in the various parts of the United States accomplish their work by methods suited to their particular localities.

A third object, informal, but of equal importance with the other two, was to enable the secretaries and editors to become personally acquainted with one another, and to learn the various characteristics of those who have been leaders in the activities of the State Societies, some of them for years.

The Editors and Secretaries of the State Societies felt that they knew the individuals that conduct the State Journals, for each journal has an individuality of its own that reflects that attitude of the medical leaders toward the acute problems of medical organization and economics. It was a privilege for a representative to greet informally an editor with whom the previous contacts had been impersonal through the pages of his journal. It was also an education to ascertain the reasons why a state sometimes approaches a medical problem from an opposite point of view from that of most other states. After attending the national conference, one can read the State Journals with some knowledge of the unseen forces which determine the direction of the action of the several state societies.

The delegates dined together in a social dinner Friday noon, and massed themselves for a group picture immediately afterward.

A profitable feature of previous meetings has been an inspection of the rooms of the American Medical Association building at 535

North Dearborn Street, and a view of the work that is done there. But the increase in the activities of the association had necessitated the use of its assembly hall. However, a moving picture of the building and the leaders at work that was shown at the conference was more impressive than the sight of the original would have been. The group picture taken on Friday will be incorporated in the movie, and the reel will be available for state societies that wish to demonstrate the varied activities of the American Medical Association.

The meeting was called to order at 10 o'clock on Friday morning by Dr. J. H. J. Upham, Chairman of the Board of Trustees of the A. M. A. Following the custom of the conference, one of the delegates was chosen Chairman, Dr. Robert L. Parker, Secretary of the Iowa State Medical Society being elected. Dr. Olin West, Secretary and General Manager of the A. M. A., was present throughout the conference, and was always ready to answer inquiries regarding the work of the Association.

The formal program consisted of addresses by nine speakers, four of whom were on the staff of the American Medical Association and five from the State Medical Societies. Each address was discussed by the state delegates up to the time limit assigned to it.

The first address was by Dr. LeRoy A. Wilkes, Executive Secretary of The Medical Society of New Jersey, whose subject was "The Medical Society of New Jersey Experiments in Furnishing Medical Service in the Community". Dr. Wilkes described the administrative mechanism by which close coordination and coöperation were maintained between the officers and committees of the State Society on the one hand, with the committees and members of the County Societies on the other.

Dr. Wilkes illustrated the working of the plan by a description of the two projects now in operation—Emergency Relief Administration, and the Public Health Hour. It seemed to be the opinion of the representatives of the other states that New Jersey had developed a workable solution to the problem of delivering medical services to all classes of persons. New Jersey first recognizes the need for a particular service, and then sets up a simple form of machinery operated by the county medical societies, for its delivery through the physicians in private practice. It is a plan of internal

evolution in which every member of the State Society is urged to take an active part.

There was an animated discussion of Dr. Wilkes' paper and numerous questions were asked him regarding the details of the operation of the projects. Requests for printed matter used were met by offers to send samples of the New Jersey materials.

Dr. Oliver J. Fay, Chairman of the Board of Trustees of the Iowa State Medical Society, described the organization of his society and the manner of conducting its activities. Several secretaries compared their own organizations with his. Although there were wide differences in the forms of the committees of the several state societies and the methods of their work, yet all seemed to produce the same results when the workers acted wisely and earnestly.

Dr. H. Douglas Singer, Chairman of the Committee on Mental Health of the American Medical Association, described the efforts of the A. M. A. to enlist the coöperation of the state societies in psychiatry, especially that branch called "mental health". The work of his committee is somewhat new and physicians will generally require considerable education and stimulation before they will consider it as a major project or will apply it in their daily practice.

"Some Problems of a State Medical Editor" were described by Dr. W. Edwin Bird, Editor of the Delaware State Medical Journal. Dr. Bird touched upon such problems as illustrations of articles, ownership of a paper read before several medical societies, and reporting society news. Dr. Bird had reckoned the proportion of space given by several medical journals to news of medical societies, and his conclusion seemed to show that the New Jersey Journal devotes much more space than the average to medical society news—one reason probably being the activity of the society in producing the news to report.

Dr. Bird prepared and delivered his address with clearness, conciseness and wit, according to the best standards of medical editorship.

Dr. James S. McLester, President-Elect of the American Medical Association, spoke on "Medical Precision" as applied to writing and editing. He set forth the standards to which authors of papers should conform, but he did not emphasize the common variety of medical writer who supposes that the work of the Editor consists of rewriting the article for publication.

Dr. Holman Taylor, Secretary of the State

Medical Society of Texas, gave an address on the Federal Emergency Relief Administration in his state. His experience was like that of the Medical Society of New Jersey, except that his Federal Administrators did not seem to be always coöperative with the physicians.

The discussion of Dr. Taylor's paper by the representatives of the several states revealed a tone of pessimism in their estimate of the coöperation showed by the Federal Emergency Relief Administrators with the physicians.

Dr. R. L. Sensenich, representing the Committee on Legislative Activities of the American Medical Association, spoke of the attitude of the medical societies of the states and counties toward the broader relations of medical practice, such as state medicine and health insurance. He left the impression that these problems would have to be solved by the medical societies dealing with the peculiar problems of their own districts.

Dr. Clyde Cummer, President of the Ohio State Medical Association, gave an address on the subject "The Educational Programs at State and County Meetings". He emphasized the point that the needs of the general practitioner rather than the specialist are to be met by the scientific programs of the states and counties.

Dr. Cummer described the Ohio organization supplying the county societies with speakers, and with courses of study. An outline of a course appears in each issue of the Ohio State Journal. He distributed reprints of a course on coronary thrombosis, and one on intestinal obstruction. The plan of their use is that the County Society shall assign subdivisions of the subject to members who shall present papers on the subject before the County Society. The project is in successful operation, especially in the smaller counties.

The last speaker at the conference was Dr. R. G. Leland, Director of the Bureau of Medical Economics of the American Medical Association, who described the operation of medical service under the governmental plan of sickness insurance that is in operation in England. The conclusion of the speaker was that inherent defects in the system make the project entirely unsuited to American medical practice.

The conference was unusually practical and inspiring in the opinion of those who have been regular attendants over a series of years. The addresses and discussions will be published in the Bulletin of the American Medical Association in accordance with the custom of previous years.

THE CHARTER, CONSTITUTION AND BY-LAWS OF THE MEDICAL SOCIETY OF NEW JERSEY

The last edition of the Constitution and By-Laws of The Medical Society of New Jersey was printed in 1929; and since that time many amendments have been adopted.

The House of Delegates on June 7, 1934, adopted a resolution introduced by Dr. Charles J. Murn, Chairman of the Committee on Constitution and By-Laws, that the Publication Committee be authorized to print the Constitution and By-Laws as amended up to the close of the Annual Meeting of 1934 (*Transactions page 39*).

THE CHARTER

The Medical Society of New Jersey was organized on July 23, 1766, by seventeen physicians of "East" New Jersey who met at "Mr. Duff's" in New Brunswick, it being the first State Medical Society to be organized in the United States. Its existence was recognized by law in 1783 and 1786; and it was incorporated by an Act of the Legislature passed on June 2, 1790, by which general powers of holding property were conferred on it. Fifty-two physicians were named in the Act as incorporators.

A second Act of Incorporation was passed on March 7, 1816, authorizing the formation of District and County Societies, which should have the power to examine candidates for licensure to practice medicine. Those who passed the examination successfully were given licenses by the President of the State Society,

authorizing them to practice anywhere in New Jersey.

An Act passed February 10, 1818, provided that the State Medical Society should be composed of four delegates from each District or County Medical Society, thereby developing the organization in the representative form in which it exists today.

The authority to grant the degree of "Medicinae Doctor" was granted to the Society in 1825; and may still be exercised according to Chapter XIV of the present By-Laws.

The present Charter of the Society was granted by the Legislature in 1864, in response to a formal request of the Society adopted on January 27, 1864. The charter which follows is reprinted verbatim from the Laws of New Jersey of 1864.

CHAPTER CLVII OF THE LAWS OF 1864

AN ACT TO REORGANIZE THE MEDICAL SOCIETY OF NEW JERSEY

WHEREAS, The medical society of New Jersey is approaching its centenary anniversary; and, whereas, the society, by petition, has expressed a desire to surrender all its special privileges and pecuniary immunities, and to reorganize, as nearly as possible, upon the voluntary basis; therefore,

1. BE IT ENACTED, *by the Senate and General Assembly of the State of New Jersey*, That the medical society of the state of New Jersey, already incorporated by the style and name of "The Medical Society of New Jersey", shall continue to be a body corporate and politic, in fact and in name, and shall and may have and use a common seal, and alter the same at their pleasure; and that the said society shall be composed of delegates (not less than three), chosen by and from each of the district or county societies, which now are, or which under the authority of the said society may be hereinafter instituted; the officers for the time being, shall be ex-officio members of the said society, independently of the authority of delegation; and all persons who

shall have been, or may hereafter be, presidents of the society, shall rank as fellows, and be entitled to all the privileges of delegated members.

2. *And Be It Enacted*, That the society shall have the authority to confer the degree of Doctor of Medicine, under such rules and regulations as they may adopt, which degree shall be deemed sufficient evidence of a regularly educated and qualified practitioner of the healing art; and hereafter no one shall be admitted to membership in any district or county society having connection with this society, unless he shall have received the said degree of Doctor of Medicine, or been admitted *ad eandem*, from some other medical authorities, which this society shall deem proper to recognize; *provided*, that this act shall not be so construed as to prevent any county or district society from admitting to membership any respectable practitioner who shall have previously to the passage of this act, received the degree of doctor of medicine from any college or university recognized by, or in affiliation

with the body known as "The American Medical Association".

3. *And Be It Enacted*, That this society shall have the power to prescribe the duties of its officers and members, fix their compensation, assess from time to time an annuity upon the district or county societies in the ratio of their membership respectively, and adopt such rules and regulations for the due management of the concerns of this and the several district societies as may be deemed necessary; *provided*, the same be not contrary to the laws of this state; and may hold any estate, real

and personal, the annual income of which shall not exceed one thousand dollars.

4. *And Be It Enacted*, That this act shall be considered a public act, and shall take effect on the fourth Tuesday of January, eighteen hundred and sixty-six; and that the act entitled "An act to incorporate medical societies for the purpose of regulating the practice of physic and surgery in this State", passed January twenty-eighth, eighteen hundred and thirty, and all supplements thereto, be and the same are hereby repealed.

Approved March 14, 1864.

Constitution

ARTICLE I—NAME

The name of this organization is "The Medical Society of New Jersey".

ARTICLE II—PURPOSE

The purposes of this society are:

To federate and organize the medical profession of the State of New Jersey;

To unite with similar organizations of other states to compose the American Medical Association;

To advance medical science, elevate professional standards, safe-guard the material interest of and promote friendly relations among members of the medical profession;

To educate the public in prevention of disease and the preservation of health; and, in general,

To render this profession most capable of serving humanity.

ARTICLE III—COMPONENT SOCIETIES

County medical societies that hold charters from this society shall be known, and referred to in the Constitution and By-Laws, as *component societies*.

ARTICLE IV—COMPOSITION OF THE SOCIETY

SECTION 1—OF WHOM COMPOSED

This society shall be composed of Fellows, Officers, Delegates, and members of Component Societies in good standing.

SECTION 2—GROUPS

(a) *Fellows*. The Fellows are the Ex-Presidents of the society.

(b) *Officers*. The Officers shall be a President, a President-Elect, two Vice-Presidents, a Secretary, a Treasurer, members of the Board of Trustees, and the Councilors.

(c) *Delegates*. Delegates shall be chosen by and from the component societies, and shall be members of this society and of the House of Delegates for the period of time for which they are elected, subject to continuance of good standing in their respective component society, and further subject to their respective component society continuing in good standing in this society.

SECTION 3—ELECTION OF DELEGATES

(a) *Apportionment*. Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at its annual meeting by a majority ballot of the members present; but, each component society shall be entitled to at least three (3) delegates. Each component society shall, at its annual meeting next following the adoption of this Constitution, elect delegates in 3 groups, for periods of 1, 2, and 3 years, respectively; and thereafter shall elect its delegates for periods of 3 years each.

(b) *Reapportionment*. In the event of subdivision of any of the existing counties of New Jersey and the creation of an additional component society, the delegates from the old and the new component societies shall be apportioned on the basis above provided, and the quota of the original component society of that district shall be correspondingly diminished.

(c) *Delinquency*. In the event that a component society becomes delinquent to this society, its entire delegation shall lose its status throughout the period of such delinquency.

(d) *Vacancies*. A vacancy shall exist in the delegation of any component society whenever one of its delegates ceases to be in good standing, or resigns, or dies. When such a vacancy occurs in any component society, its secretary shall promptly so notify the secretary of this society, in writing; and, after

acknowledgment of receipt of such notice, the component society shall, at a regular or special meeting, fill the unexpired term of such vacancy by election of a new delegate, by a majority ballot of the members present.

(c) *Alternates.* Each component society shall elect, at its annual meeting, an alternate delegate for each regular delegate, and the latter, if unable to attend the annual meeting (or any regularly called meeting) of this society, shall assign his delegate's card to an alternate. An alternate, when serving, shall have all the rights and privileges of a regular delegate; and, when registered and seated in the House of Delegates, shall retain his seat during that entire meeting.

SECTION 4—MEMBERS OF COMPONENT SOCIETIES

All members of component societies in good standing are hereby constituted members of this society and entitled to participate in all the privileges of general and scientific sessions.

SECTION 5—HONORARY MEMBERS

Honorary members shall be physicians and surgeons who have attained distinction within the medical profession, and who may be elected by a two-thirds vote of the House of Delegates after having been recommended by the Committee on Honorary Membership; provided the number of living Honorary Members does not exceed fifteen (15). They shall have all the privileges of members, but shall not be members of the corporate body.

SECTION 6—GUESTS

Any physician, resident or non-resident of New Jersey, may, upon invitation of this society or its House of Delegates, become a Guest during the annual meeting, and shall thereby be accorded the full privileges of the scientific sessions.

ARTICLE V—HOUSE OF DELEGATES

The House of Delegates shall be the *legislative* body, and shall consist of the Fellows, Officers and Delegates.

ARTICLE VI—BOARD OF TRUSTEES

The Board of Trustees shall be the *executive* body, and shall be composed of the President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and eleven (11) members—at least two (2) from each judicial district—who shall be elected as follows:

At the first election of officers following the adoption of this Constitution, three (3) mem-

bers shall be elected for a period of one (1) year; four (4) members for a period of two (2) years; four (4) members for a period of three (3) years; and, as the terms of these elected Trustees expire, new elections shall be for periods of three (3) years each.

ARTICLE VII—COUNCILORS

The House of Delegates shall organize five (5) councilor districts within the state. This society shall elect one (1) councilor from among the delegates of each such district; and these elected councilors, collectively, shall constitute the Judicial Council.

ARTICLE VIII—MEETINGS

SECTION 1—GENERAL SESSION

This society shall hold an annual meeting, during which there shall be at least one general session that shall be open to all registered members.

SECTION 2—SECTIONS

The House of Delegates or the Board of Trustees may provide for division of the scientific work of the society into appropriate sections whenever necessity therefor arises.

SECTION 3—TIME AND PLACE OF ANNUAL MEETING

The time and place for said annual meeting shall be fixed by the House of Delegates for each succeeding year. The Board of Trustees may change the time and place when necessary.

ARTICLE IX—OFFICERS

SECTION 1—TERM OF OFFICE

The Officers, except the Councilors and members of the Board of Trustees, shall hold office for one year, or until their successors are elected and installed.

SECTION 2—ELECTION

The Officers shall be elected by this society, by ballot on the second day of the annual meeting. No member shall be eligible to more than one office at the same time, except the President, President-Elect and two (2) Vice-Presidents, Secretary and Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office occurring between annual meetings may be filled *ad interim* by the Board of Trustees.

ARTICLE X—FUNDS AND EXPENSES

SECTION 1—FINANCES

Current expenses of this society shall be met by an annual *per capita* assessment upon the members of each component society; by dona-

tion; by sale of the society publications; and from miscellaneous revenue. During the annual meeting, funds may be appropriated by the House of Delegates for the expenses of the annual meeting, for publications, for expenses of officers and committees, but for no other purpose, unless authorized by a two-thirds vote of the members of the House of Delegates then present, and approved by the Board of Trustees.

SECTION 2—INCURRING EXPENSE

The Board of Trustees may incur any necessary expense *ad interim*.



Seal of the Medical Society
of New Jersey

By-Laws

CHAPTER I—MEMBERSHIP

SECTION 1—PERSONNEL

The Fellows and Officers of, and all the elected delegates to, the Medical Society of New Jersey, and the members of component societies in good standing are members of this society. Honorary members are entitled to the rights given them by the Constitution.

SECTION 2—OFFICIAL LISTS OF MEMBERS

(a) February first in each year is the final date for closing the official list of members. Five days before this date the treasurer of each component society shall forward to the secretary and to the treasurer of this society a complete list of all paid-up members, with their correct addresses. After this date no name shall be accepted for the official list.

(b) On the first day of February in each year, the secretary of each component society shall send to the secretary of this society the following information: names of the officers, reporter and censors, member of the nominating committee, delegates and alternates to this society, complete list of associate members, members elected, deceased, and those who have resigned or moved from the county during the preceding year. Where members have

ARTICLE XI—SEAL

The seal heretofore adopted and now in use shall continue, unless otherwise ordered, to be the Seal of the Medical Society of New Jersey.

ARTICLE XII—AMENDMENTS

This Constitution may be amended by a two-thirds vote of the members present at any annual meeting, provided the proposed amendments have been considered by the Committee on Revision of Constitution and By-Laws, and that they shall have been submitted in writing at a previous annual meeting, shall have been published in the Journal of this society, and officially sent to each component society at least three (3) months before the annual meeting at which final action is to be taken.

transferred or have been received on transfer, the name of the county or state society to or from which they have transferred must be given.

(c) Upon request of the Secretary, the secretary of each component society shall furnish complete lists of the names of all affiliated and non-affiliated physicians resident in the county.

(d) The Official List as published each year shall be *prima facie* evidence of the right of members to register at the annual meeting, and, unless otherwise ordered by the House of Delegates, shall form the basis of representation of each component society; except that after the Official List is printed, any component society which finds that it is entitled to additional delegates and alternates may elect these at its April or May meeting.

SECTION 3—INELIGIBILITY

No person who is under sentence of suspension or expulsion from any component society, or whose name has been dropped from its roster shall be entitled to any of the rights or privileges of this society, nor shall he be permitted to take any part in any of its proceedings, until relieved of such disability.

SECTION 4—REGISTRATION AT ANNUAL MEETING

All members and delegates in attendance at the annual meeting of this society shall write their names and addresses in the registration book; failing to do so, they shall be considered as absent.

SECTION 5—CREDENTIALS

(a) All delegates shall present to the Committee on Credentials a certificate, bearing the seal of this society and the signature of its secretary. No delegate will be permitted to register or sit as a member of the House of Delegates without such certificate, nor if the component society of which he is a delegate has not paid its annual assessment.

(b) The annual assessment of a component society shall be the dues of at least the smallest number to whom a charter may be granted to form a component society, in accordance with Chapter X, Section 2, of these By-Laws.

SECTION 6—BADGE

When a member's right to membership has been verified by the Committee on Credentials, he shall receive a certificate or badge which will be evidence of his right to the privileges of membership. No member or delegate shall be permitted to take part in the proceedings of this society until the provisions of this chapter have been fulfilled.

CHAPTER II—MEETINGS**SECTION 1—ANNUAL MEETING**

This society shall hold an annual meeting at such time and place as may be fixed by the House of Delegates or by the Board of Trustees.

SECTION 2—SPECIAL MEETINGS

Special meetings of this society or of the House of Delegates shall be called by the President upon the petition of twenty or more members representing four or more component societies, or upon request of the Board of Trustees.

CHAPTER III—CONDUCTING THE SESSIONS**SECTION 1**

All registered members may attend and participate in the proceedings and discussions of the general and section meetings. The general meetings shall be for the presentation of the addresses of the President and President-Elect, orations by invited guests, and scientific papers and discussions as provided for in the official program; these meetings shall be presided over by the President, President-Elect or one of the Vice-Presidents. Special section meetings shall be for the presentation of scientific papers and

discussions related to the medical or surgical specialty designated and as provided for in the program; these section meetings shall be under the guidance of a presiding officer chosen by each section at its last session of the preceding annual meeting.

SECTION 2—COMMITTEES

The general and section meetings may create committees for scientific investigations of special interest or importance to the profession or public, and may receive and dispose of such committee reports; but no expense shall be incurred in connection therewith until authorized by the House of Delegates and approved by the Board of Trustees.

SECTION 3—PROGRAMS

The order of exercises, papers and discussions, as set forth in the official program, shall be followed from day to day until completed; unless otherwise ordered by the society.

SECTION 4—LENGTH OF ADDRESSES

No address or paper, with the exception of those delivered by the President, President-Elect, and invited orators, shall occupy more than twenty minutes in its delivery or reading; and no member shall speak longer than five minutes, nor more than once, on any subject, unless by permission of the society.

SECTION 5—OWNERSHIP OF PAPERS

All papers and reports presented to the society shall become its property, and when read shall be deposited with the Secretary. Permission to publish such papers in the Journal of the society or in other medical journals may be granted by the Committee on Publication.

CHAPTER IV—HOUSE OF DELEGATES**SECTION 1—MEETINGS**

The House of Delegates shall meet on the first day of the annual meeting of the society, but may meet in advance of or after adjournment of the annual meeting. Sessions may be adjourned from time to time, as may be necessary, but shall be so arranged as not to conflict with the general meetings of the society.

SECTION 2—QUORUM

Twenty members, representing at least four component societies in good standing, shall constitute a quorum. Sessions of the House of Delegates shall be open to all members of the society, but only members of the House of Delegates shall have the right of voice or vote.

SECTION 3—CHARTERS

It may issue charters to county societies applying for affiliation with this society.

SECTION 4—AUTHORITY OVER COMPONENT SOCIETIES

It shall consider the reports of component societies, and have authority to make such recommendations and adopt such measures as may be deemed effective for building up and increasing the interest of these societies.

SECTION 5—APPEALS

It shall hear and finally determine all appeals taken from decisions of the Judicial Council.

SECTION 6—FINAL AUTHORITY

The House of Delegates or Board of Trustees must approve all memorials and resolutions issued in the name of the society before they can become effective.

SECTION 7—BUSINESS DURING THE LAST SESSION

Unanimous consent shall be required for the introduction of new business at the last session of the House of Delegates during the annual meeting, except when presented by the Board of Trustees or the Committee on Finance. All new business so presented shall require a three-fourths affirmative vote for adoption.

CHAPTER V—SELECTION OF OFFICERS

SECTION 1—NOMINATING COMMITTEE

Each component society shall elect at its annual meeting one of its elected delegates to serve as a member of the Nominating Committee of this society, and one of its elected delegates alternate thereto; this elected member, or his alternate, shall present his credentials to the Secretary at the close of the first session of the annual meeting. The Junior Past-President of this society shall be the member of the Nominating Committee representing the Fellows; if he shall not be able to serve, then at the close of the first session of the annual meeting the Fellows shall elect one of their number to be a member of the Nominating Committee, who shall forthwith present his credentials to the Secretary. The delegates, or their alternates so elected from their respective component societies, and the representative of the Fellows, shall compose the Nominating Committee. This committee shall meet at 8.30 p. m. on the first day of the annual meeting and report the result of its deliberations to the House of Delegates in the form of a ticket containing nominations for each of the offices to be filled, including Trustees, Standing Committees, Councilors, Delegates to the American Medical Association and to other medical organizations.

SECTION 2—PROCEDURE

(a) The Chairman of the Nominating Committee shall be the Junior Past-President of the society or the member elected by the Fellows. The committee shall elect one of its own members to serve as secretary and to call the roll of accredited members of the committee as certified by the Secretary of the society. Nominations for all offices, standing committees, delegates to the American Medical Association and other medical organizations, shall be made by individual alphabetic roll call of the counties, the representative from the Fellows being called last. The representative of each county, when its name is called, may place in nomination a candidate, second a nomination, or waive its privilege to another county. The representative of the county so favored may then nominate a candidate or second a nomination, after which the roll call will be continued from the point where it was interrupted. The representative of the Fellows may nominate a candidate or second a nomination, and shall have a vote equal to the vote of a representative of a component society. The secretary shall announce the result on the completion of each call; and if the tabulation of any roll call be challenged, the roll will again be called. A majority vote of the members present shall nominate, and in the event that no candidate has received a majority of the votes cast, the name of the candidate receiving the least number of votes shall be dropped and the call of the roll shall be repeated until a nomination is made.

(b) The Nominating Committee at the first election following the adoption of these By-Laws shall submit to the society the names of two Fellows, selected by the Fellows, as nominees for the Board of Trustees. As the terms of Fellows so nominated and elected Trustees expire, the Fellows shall propose their successors to the Nominating Committee; and the committee shall submit to the society the names of the Fellows so proposed, as nominees for Trustees.

(c) The Secretary of the society shall furnish to the committee such information as is necessary for the proper conduct of its business, including a list of all officers, committees and delegates to be nominated.

(d) Nothing in this section is to be construed as preventing the nomination and election of additional Fellows to the Board of Trustees.

(e) The election of Trustees shall conform to the provisions of Article VI of the Constitution.

(f) The chairman shall read to the com-

mittee this section of the By-Laws (Section 2, Chapter V) before proceeding to any other business.

SECTION 3—TIME OF REPORT

The report of the Nominating Committee, and the election of officers, standing committees, delegates to the American Medical Association and other medical organizations, shall be the first order of business of the society in the afternoon of the second day of the annual meeting.

SECTION 4—NOMINATIONS FROM THE FLOOR

Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the society; except that the President-Elect shall succeed to the office of President without process of nomination and election.

SECTION 5—MANNER OF VOTING

All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect.

SECTION 6—BEGINNING OF TERM OF OFFICE

Officers and members of elected standing committees shall assume office immediately after adjournment of the annual meeting at which they were elected.

CHAPTER VI—DUTIES OF OFFICERS

SECTION 1—PRESIDENT

The President shall preside at all meetings of this society and of the House of Delegates. He shall appoint all committees not otherwise provided for, and shall be ex-officio member of all standing committees except the Nominating Committee. He shall deliver an address at the annual meeting of this society, and shall perform such other duties as custom and parliamentary usage may require.

SECTION 2—PRESIDENT-ELECT AND VICE-PRESIDENTS

The President-Elect and the Vice-Presidents shall assist the President in the discharge of his duties, and in his absence or disability the President-Elect, or the ranking Vice-President shall preside at all meetings of the society and of the House of Delegates, and perform all the duties pertaining to the office. In case of vacancy in the office of President by death, resignation, or removal, the President-Elect, and in his absence, the ranking Vice-President shall perform all duties pertaining to that office until the vacancy is filled by appointment of the Board of Trustees.

SECTION 3—SECRETARY

The Secretary shall attend the meetings of this society and of the House of Delegates and shall keep records of their respective meetings. He may engage stenographers to record the transactions of the annual meeting and of its various sections.

He shall issue notices of all regular and special meetings of the society and the House of Delegates; and shall conduct the official correspondence, notifying officers, members of committees, delegates to the American Medical Association and to other medical societies, of their election or appointment, and their duties.

Under direction of the Committee on Publication he shall issue annually, as soon after the first of March as possible, the Official List and Directory of the members of this society, and, by counties, of the component societies.

He shall keep a record of all elected delegates, reporting to this society and to each component society the number of delegates to which it is entitled; noting the increased or decreased strength of their delegation on the basis of representation according to the Official List.

He shall submit an annual report to the House of Delegates, and such reports to the Board of Trustees, the Judicial Council and the several committee chairmen as may be required; he shall hold himself in readiness to advise and aid the officers, committees and component societies in promoting the purposes and policies of the society; and shall perform such other duties as may be properly assigned him by the House of Delegates.

The Secretary shall be a salaried officer, and may employ assistants when authorized by the House of Delegates or the Board of Trustees.

SECTION 4—TREASURER

The Treasurer shall give bond, at the expense of the society, in such amount as may be required by the Board of Trustees. He shall demand, receive and preserve all funds due the society, together with bequests and donations; and keep a correct list of the same, with the name of each donor. He shall not pay any money out of the treasury except on resolution of the Board of Trustees, or upon voucher of the office or committee responsible for the expenditure, countersigned by the Chairman of the Finance Committee, and as provided in the annual budget. His accounts shall be audited by the Trustees at such times as the Board or the House of Delegates may order, and he shall render at each annual meeting of the society a full statement of all transactions of his office. Whenever 90 per cent of

the annual budget appropriated for any office or committee has been expended, he shall so notify the proper officer or committee chairman. He shall charge upon his books the assessment against each component society at the end of the fiscal year, collect and make proper credits for the same; and perform such other duties as may be assigned to him.

SECTION 5—BOARD OF TRUSTEES

(a) *Organization.* At the first meeting of the Board of Trustees following each annual meeting of the House of Delegates, the Board shall organize by electing a chairman and a secretary; and the chairman shall appoint such committees as may seem necessary or desirable. Meetings shall be called by the chairman, but any four members may require the chairman to call a meeting for such time and place as shall be designated by them in writing. Members shall have at least five days advance notice of all meetings. Nine members shall constitute a quorum.

(b) *Powers.* The Board shall exercise general supervision over the affairs of the society, with authority to act for the society between annual meetings, and to perform the following functions:

- To make recommendations to the House of Delegates;
- To advise in the deliberations of the several standing committees;
- To supervise the work of the Publication Committee and, when necessary, to appoint an editor and such other assistants as the needs of the society may require;
- To determine all salaries;
- To pass upon all recommendations for incurring expense, over and above that provided in the budget;
- To order all necessary expenditures;
- To refer and otherwise dispose of all business, properly arranged for its disposition;
- To require and hold the official bond of the Treasurer and to annually audit his accounts;
- To fill vacancies in all offices and elected standing committees until the next annual meeting.

In the event of a vacancy in the office of Treasurer, by death or otherwise, the Board of Trustees shall select one of its members to fill the vacancy.

(c) *Property.* It shall have authority to lease, sell, or otherwise convey or dispose of any or all property of the society, both personal and real, and to execute therefor, good and sufficient lease, deed, or other conveyance.

(d) *Finance Committee.* Three of its members shall serve on the Committee on Finance

in accordance with Chapter VIII, Section 5, of these By-Laws.

(e) *Nominees to State Board of Medical Examiners.* Acting for the society, and in accordance with the statutes of this state, as vacancies occur in the State Board of Medical Examiners by reason of the expiration of term, or otherwise, of members of said Board representing this society, the Trustees shall nominate for each appointment three members of this Society, and the names of such nominees shall then be transmitted by the President of this society to the Governor of the state.

(f) *Annual Report.* It shall publish annually in the Journal of this society a report of its proceedings and recommendations, and shall render to the House of Delegates a summary of its activities.

CHAPTER VII—JUDICIAL COUNCIL

SECTION 1—ELECTION

The Councilors shall be elected as follows: At the first election of officers following the adoption of these By-Laws, two (2) members shall be elected for a period of three (3) years; two (2) members for a period of two (2) years; and one (1) for a period of one (1) year; and as the terms of these elected Councilors expire, new elections shall be for periods of three (3) years.

SECTION 2—CENSORS

The Councilors collectively, shall constitute a Board of Censors of this society known as the Judicial Council.

SECTION 3—MEETINGS

The Judicial Council shall meet on the evening before the annual meeting of the society, and subsequently at the call of the chairman or upon the petition of three of the Councilors, at such time and place as necessity or convenience require. Four members shall constitute a quorum.

SECTION 4—ETHICS AND DISCIPLINE

All questions of an ethical nature shall be referred to the Judicial Council without discussion. It shall consider and decide all questions of discipline affecting the conduct of members. It shall consider all questions involving the rights of members, whether in relation to each other, to component societies, or to this society.

SECTION 5—APPEALS FROM ACTION OF JUDICIAL COUNCIL

(a) Any aggrieved member of a component society, or applicant who may have been excluded from membership in such society,

may appeal from its action to the Judicial Council.

(b) The notice of appeal shall set forth in writing the name of the appellant, the name of such component society, the date and substance of the questioned decision, and shall indicate the grounds upon which such appeal is taken.

(c) Upon filing a notice of appeal, the appellant and the component society must submit to the Secretary of this society all records, minutes, letters, papers and written evidence, including a digest of all testimony whether or not stenographically reported, relative to the matter. All data so submitted shall be confidential and privileged, and made available only to the Judicial Council and its respective members. In case of an appeal being taken from the decision of the Council to the House of Delegates, all such data must then be submitted to the House of Delegates or to a committee appointed by that body to consider the appeal.

(d) The Judicial Council shall consider any appeal on the data so submitted, and may affirm by a majority vote, modify, or reverse by a two-thirds vote of its members present and voting, the appealed decision. If, in its opinion, further evidence is desirable, the Judicial Council may summon witnesses, take such evidence in any manner it may deem proper, and render its decision by a two-thirds vote of the members present and voting; and all its decisions shall be binding unless or until reversed or modified by the House of Delegates.

SECTION 6—DUTIES OF COUNCILORS

Each Councilor shall visit each component society in his district at least once a year, for the purpose of inquiring into the condition of the profession and effecting close coöperation with this society; and shall conduct, at least once a year, a joint meeting of the delegates and alternates of the component societies of his district. He shall make an annual report to the House of Delegates on the results of his observations in each component society. The necessary traveling expenses incurred by Councilors in the line of the duties here imposed may be approved and allowed by the House of Delegates upon presentation of proper itemized statements.

CHAPTER VIII—COMMITTEES

SECTION 1—CLASSIFICATION

There shall be Standing Committees, Reference Committees, and Special Committees.

SECTION 2—STANDING COMMITTEES

The Standing Committees shall be:

Nominating Committee,
Committee on Finance,

Scientific Work,
Program and Arrangements,
Publication,
Honorary Members,
Welfare,
Hospitals and Medical Education,
Committee on Medical Defense,
Committee on Insurance,

and such other committees as the House of Delegates shall determine.

SECTION 3—APPOINTMENTS

Standing Committees, unless otherwise provided, shall be appointed by the President, and he shall designate the chairmen. The President shall be a member ex-officio of all the above named committees except the Nominating Committee. Unless otherwise ordered in these By-Laws, committee members shall serve for three years; provided that in committees of three members no two terms shall expire in the same year; and in committees of six members not more than two terms shall expire in the same year.

SECTION 4—NOMINATING COMMITTEE

The Nominating Committee shall be selected and shall function according to the provisions of Chapter V of these By-Laws.

SECTION 5—COMMITTEE ON FINANCE

The Committee on Finance shall consist of three members elected by and from the Board of Trustees, and three members elected by and from the House of Delegates, and their term of office shall be for six years; provided that the term of one Trustee member shall expire every second year, and the term of one Delegate member on each alternate year. The Treasurer shall be a member ex-officio, his capacity being advisory and without vote except in case of tie. The committee shall elect its own chairman. It shall prepare a budget to be submitted to the House of Delegates at the annual meeting, and it shall control the expenditure of money by officers and committees, as provided in Chapter IX of these By-Laws. The committee is hereby authorized to require from any officer or committee any necessary fiscal information.

SECTION 6—SCIENTIFIC COMMITTEE

The Committee on Scientific Work shall consist of three members, and shall have oversight of the scientific work of this society, and act in an advisory capacity regarding similar work in component societies. It shall arrange for papers, addresses, and orations for the annual meeting, and shall otherwise extend the scientific work of the society as it may elect; and shall render a report to the Program Commit-

tee at least six weeks before the annual meeting. It shall acquaint those who are to be on the program of that meeting, with the conditions attached thereto.

SECTION 7—PROGRAM AND ARRANGEMENTS COMMITTEE

The Committee on Program and Arrangements shall consist of three members, elected by the House of Delegates, with the President and Secretary as additional members ex-officio. It shall provide suitable accommodations for the annual meeting, viz: for the general and section sessions, House of Delegates, Trustees, committees, Woman's Auxiliary, and exhibits. It shall have charge of all details pertaining to the general arrangements. After receiving from the committee on scientific work the titles and abstracts of papers, with the authors' names attached, it shall, at least four weeks before the annual meeting, issue a program of the entire session, giving the sequence of papers, discussion, and business sessions; and this order shall be followed as nearly as practicable. When the outline of arrangements has been approved by the President and a joint meeting of this committee with the Committee on Scientific Work, it shall have the program and announcements printed, and a copy mailed to each member of the society.

SECTION 8—PUBLICATION COMMITTEE

The Committee on Publication shall consist of three members elected by the House of Delegates, with the Secretary an additional member ex-officio, and the Editor of the Journal sitting with the committee in an advisory capacity. It shall publish and distribute the Journal. Reports, papers, and discussions may be submitted to this committee for publication in the Journal; but the committee shall have authority to curtail or abstract, or to return to the author, such material as seems to it unsuitable for publication, with a statement of the reasons therefor.

SECTION 9—HONORARY MEMBERSHIP COMMITTEE

The Committee on Honorary Membership shall be composed of three Fellows. It shall inquire into the standing and qualifications of all nominees for honorary membership in the society, and report the same with recommendations to the House of Delegates.

SECTION 10—WELFARE COMMITTEE

The Welfare Committee shall consist of thirty-five (35) members, appointed annually, which number shall include the President and Secretary of this society, ex-officio. Each component county society shall be represented by at least one member, and candidates for such

appointment may be suggested to the President by each component society. The committee shall elect one of its members to act as chairman and executive officer. It shall keep minutes and records of its transactions. It shall have supervision over legislative matters, public health, and public relations, subject when necessary to direction from or approval by the Board of Trustees or the House of Delegates. To this committee shall be referred all questions of professional welfare not included in the specific work of the Judicial Council. It shall be empowered to employ a special agent or agents, and to expend such moneys as shall be approved by the Committee on Finance and the Board of Trustees.

SECTION 11—HOSPITALS AND MEDICAL EDUCATION COMMITTEE

The Committee on Hospitals and Medical Education shall consist of three members. It shall supplement or extend, as necessary, the work of the Hospital Standardization Committees of the American Medical Association, American College of Surgeons, and American College of Physicians, and may consider hospital problems in general. It shall coöperate, when feasible, with the State Board of Medical Examiners, or other organizations, in matters affecting hospitals, hospital interns, and nursing. It shall advise concerning postgraduate study by members of this society.

SECTION 12—MEDICAL DEFENSE COMMITTEE

The Committee on Medical Defense shall consist of five members, appointed annually; and shall have charge of all matters pertaining to alleged malpractice of members. It shall maintain contact with the Judicial Council, and refer questions of an ethical nature to that body.

SECTION 13—INSURANCE COMMITTEE

The Committee on Insurance shall consist of seven members, appointed annually. It shall arrange with carriers for various types of insurance, except professional liability, to be available to members, and covering particularly health, accident, life, and automobile. It shall supervise the application of such insurance to members of the society.

SECTION 14—REFERENCE COMMITTEES

Immediately after the organization of the House of Delegates at each annual meeting the President shall appoint, from the members of the House, reference committees of five members each, unless otherwise provided, to serve during the session at which they are appointed. To these committees may be referred any re-

ports, resolutions, measures, or propositions which have been presented to the House. When a matter is referred to any such committee, it shall meet forthwith, discuss the question referred, hear debate thereon by any interested member of the society, and shall submit its recommendations at the next session of the House for action.

SECTION 15—NAMES OF REFERENCE COMMITTEES

There shall be the following Reference Committees, and any others to be created by the House of Delegates as need arises:

- (a) Credentials—to consist of one member to serve with the Secretary and the Treasurer, who are members ex-officio.
- (b) Resolutions and Memorials.
- (c) Constitution and By-Laws.
- (d) Miscellaneous Business.

SECTION 16—CONTINUANCE OF FUNCTION

On the order of the President or House of Delegates any reference committee may be created a *special* committee in order to continue, after the annual meeting, work which has been initiated but which cannot be completed during that meeting; but there shall be a strict limitation, in the order for its continuance, as to its function and term of life.

SECTION 17—SPECIAL COMMITTEES

Special committees may be created by the House of Delegates or by the Board of Trustees. They shall be appointed by the President, or the Chairman of the Board of Trustees, and their specific functions and term of life shall be clearly defined. The limitations in regard to incurring expense provided for in Chapter III, Section 2, of these By-Laws shall apply also to these committees.

SECTION 18—ADDING TO SIZE OF COMMITTEE

The President may at any time, on request of any committee, appoint additional members thereto, in order to meet unexpected or unusual demands on that committee; provided that the term of such emergency appointees shall cease with the close of the next annual meeting of the society.

CHAPTER IX—FINANCE

SECTION 1—PERMANENT FUND

(a) There is hereby established in the custody of the Treasurer a Permanent Capital Fund, to consist of any money which may come to the Medical Society of New Jersey by gift or bequest and not otherwise designated, any balance remaining unexpended at the close of the fiscal year which the Board of Trustees may direct to be added to this fund, and such

other money as may from time to time be available for this purpose.

(b) This fund shall be deposited or invested by the Treasurer in such manner as is by law provided for trust funds, or as the Board of Trustees may direct. The income from such funds may be used for the general purposes of the society, unless otherwise ordered, but the principal of the fund may be expended only for purposes of permanent value to the Medical Society of New Jersey, when so ordered by a two-thirds vote of the House of Delegates, such expenditure having previously been approved by the Board of Trustees and notice of such approval sent to the component societies at least one month in advance of the meeting of the House of Delegates at which action is taken.

SECTION 2—GENERAL FUND

(a) *Annual Assessment of Members.* On the first day of January in each year there shall be levied on each component society a *per capita* assessment on the membership of such component society, as hereinafter set forth (Par. b), to be paid to the Treasurer of the Medical Society of New Jersey not less than five days before the first of February, together with a list of the members for whom such payment is made. A similar *per capita* assessment shall be paid in the same manner immediately upon the admission or reinstatement of any such member, except that for a new member admitted after October first of any calendar year, one-quarter of the regular assessment shall be paid. Every member for whom the assessment is paid shall be listed as a subscriber to and entitled to receive the Journal.

(b) *Estimating the Assessment.* Two weeks before the annual meeting each officer and standing committee shall send to the Chairman of the Committee on Finance an estimate of the amount of money necessary for the work of his office during the next fiscal year. The Committee on Finance shall then proceed to consider and determine the amount of money to be raised, fix the *per capita* assessment to be levied on the component societies, and report its recommendations to the House of Delegates at the first session of that body. This report may then be approved, amended, or rejected by the House of Delegates, but final action on it shall not be taken before the last session of the meeting.

(c) *The Budget.* No officer or committee may spend more money than the amount allowed in the budget without approval of the Committee on Finance, which may, however, apportion to such officer or committee, on application, any unexpended balance of other

items; provided that the total amount disposed of by the Finance Committee must not exceed the total amount voted by the House of Delegates, unless by special authority of the Board of Trustees.

SECTION 3—FISCAL YEAR

The fiscal year of the society shall begin on the first day of June, and the financial report of the Treasurer and of all officers and committees shall be for this period. The budget estimates and appropriations shall likewise be for the same period.

SECTION 4—SPECIAL BUDGETS

All motions and resolutions appropriating money for special purposes shall fix a definite sum, and shall state the budget account against which the expenditure is to be charged. Such resolutions must be passed by the House of Delegates and approved by the Board of Trustees.

CHAPTER X—COMPONENT SOCIETIES

SECTION 1—CHARTERS

County medical societies of this state that shall adopt the principles of organization in accord with the Constitution and By-Laws of this society may, upon application to the House of Delegates, receive a charter, and thereby become a component society in affiliation with the Medical Society of New Jersey as hereinafter provided.

SECTION 2—CONDITIONS OF CHARTERING

Charters shall be issued to county societies having at least ten members, under seal of the Medical Society of New Jersey and signed by the President and Secretary; but there shall be only one component society chartered in each county. Upon recommendation of the Board of Trustees, this society may revoke the charter of any component society whose actions are in conflict with the letter or spirit of the Constitution and By-Laws.

SECTION 3—QUALIFICATIONS OF MEMBERS

(a) *Judging Qualifications.* Each component society shall be the judge of the qualifications of its own members, subject to the right of approval of this society; but, as such societies are the only portals to this society and to the American Medical Association, it is recommended that every reputable and legally registered physician shall be deemed eligible to membership in a component society.

(b) *Biographies of New Members.* When a physician applies for membership or when an application is made to be received on transfer, the secretary of the component society shall forward his name and address to the

biographic department of the American Medical Association for such information as may be on file relative to his record. Printed forms for this purpose will be furnished by the Secretary of this society. After the adoption of these By-Laws, no new member shall be enrolled or accepted on transfer until this provision shall have been carried into effect.

(c) *Probationary and Associate Members.* Each component society, as a requisite of eligibility to active membership, may require applicants to serve a probationary period of not longer than two years in the society as associate members. Associate members shall have such privileges in component societies as the Constitution and By-Laws of the respective societies may provide, except the right to vote and hold office. Their dues shall be those fixed by their respective component society, plus the subscription price of the Journal as determined by the Board of Trustees.

SECTION 4—APPEALS

Any physician who may feel aggrieved by the action of a component society in refusing him membership, or any member of a component society who has been suspended or expelled, shall have the right of appeal through his District Councilor to the Judicial Council. The powers of the Judicial Council and its method of procedure are defined in Chapter VII of these By-Laws.

SECTION 5—TRANSFERS

When a member in good standing in a component society moves to another county of this state, his name, upon request, may, by a majority vote of those present, be transferred to the roster of the component society into whose jurisdiction he moves.

SECTION 6—JURISDICTION

Any physician living on or near a county line may hold his membership in the component society most convenient for him to attend, on permission from the component society in whose jurisdiction he resides; *provided that* no physician may be a member of two component societies at the same time, nor of this society and another state society.

SECTION 7—REPORTERS

Each component society shall elect a reporter, who shall furnish the Editor with brief reports of its meetings and of items of interest concerning the society and its members, extracts of papers and interesting case reports, notice of the prevalence of contagious and other diseases in the county, and the election, removal or death of members.

CHAPTER XI—RESIGNATION OR REMOVAL OF OFFICERS

Any officer of this society may resign his office, or he may be removed therefrom by a two-thirds vote of the House of Delegates, when guilty of neglect of duty, improper conduct, or upon violation of the Constitution and By-Laws. In either or all cases the society shall fill the vacancy so made as provided for in Article IX of the Constitution, and in Chapters V and VI of the By-Laws.

CHAPTER XII—RULES OF CONDUCT

The "Principles of Medical Ethics" adopted by the American Medical Association shall govern the conduct of the members of the Medical Society of New Jersey in their relations to each other and to the public.

CHAPTER XIII—RULES OF ORDER

The deliberations of the society shall be governed by parliamentary usage as contained in Roberts' "Rules of Order", when not in conflict with this Constitution and By-Laws, unless otherwise determined by a two-thirds vote of its respective bodies.

CHAPTER XIV—CONFERRING THE DEGREE OF DOCTOR OF MEDICINE

Candidates for the degree of *Medicinæ* Doctor may apply to any component society of this state, and shall be admitted to examination under the following rules and regulations:

First. Each component society shall appoint annually, or *pro re nata*, a committee of not less than five members, who shall conduct the examinations.

Second. All examinations shall be in the presence of the Medical Society of New Jersey at a regular meeting; and no candidate

shall be examined until he has given satisfactory evidence of having reached the age of twenty-one years, is of good moral character, that his preliminary education has been such as to qualify him for the study and practice of medicine, and has pursued his medical studies in some medical college whose requirements do not fall below the minimum standard of the Association of American Medical Colleges.

Third. The examination shall extend to all of the branches taught in the medical schools recognized as aforesaid; and the candidate shall then be balloted for by the Medical Society of New Jersey. If he shall receive the approving votes of two-thirds of all the members present, the presiding officer shall give a certificate to that effect to the candidate.

Fourth. The certificate may be presented at the next or any subsequent regular meeting of the Medical Society of New Jersey, not extending beyond the period of three years, with a written thesis upon some medical subject; and if, upon a ballot, he shall be approved by a majority of the members present, the candidate, upon the payment of fifteen dollars, shall be entitled to receive a diploma in the following form: (Here follows the form of diploma.)

CHAPTER XV—AMENDMENTS

These By-Laws may be amended at any annual meeting of the Medical Society of New Jersey by a two-thirds vote of the members present, provided that at least fifty members are present; and, provided further, that the amendments shall have been submitted to the Committee on Constitution and By-Laws, and shall have been twice read in open meeting and laid upon the table for one day.

Upon the adoption of this Constitution and these By-Laws all previous Constitutions and By-Laws are thereby repealed.

SECRETARIES' AND REPORTERS' CONFERENCE

Plans are being made to hold the Annual Conference of Secretaries and Reporters of the County Societies on Wednesday, November 7, 1934. The details of the place and the program have not been completed; but notice will be sent to each Secretary and Editor in the near future.

The general purpose of the Conference is announced in the first editorial in this issue of

the Journal (page 553); and two practical topics for discussion are suggested in editorials on pages 557 and 558. There will be no addresses delivered or papers read; but the representatives will occupy the greater part of the time in expressing their reactions to the editorials and to other suggestions arising from the experience of the central office in the relations with the secretaries and editors.

THE WELFARE COMMITTEE

The Welfare Committee held its organization meeting on Sunday, September 23rd, at 2:30 p. m., at the Stacy Trent Hotel, in Trenton, with the following members present: Drs. Ely, Alexander, Areson, Blumberg, Coleman, Dandois, Frost, Haggerty, Hoffman, Lawton, Lee, Lewis, Morris, Morrison, Nichols, Pyle, Rogers, Sewall, Schwarz, Ulmer, and Wilson; and Dr. Wilkes, Secretary.

President Ely presided while the organization of the meeting was perfected. Dr. Thomas K. Lee, of Camden, was unanimously elected Chairman.

ADDRESS OF THE PRESIDENT OF THE STATE SOCIETY

Dr. Ely read the following address in which he briefly outlined his plans for the coming year:

"As we begin another year of medical activities within our State I am gratified with the coöperation you have each expressed in your acceptance of appointments to this Welfare Committee. This committee with its sub-committees is the *working* organization of our State Society, and the Board of Trustees, the *governing* body. Appreciating, therefore, the importance of the work of the Welfare Committee, let us put forth the best of our efforts.

"The sub-committees, the Uniform Medical Practice Act Committee, the Medical Practice Committee, the Public Health Committee, and the Workmen's Compensation Committee have been following out plans formulated a year ago, or earlier. At our annual convention these committees presented excellent reports and recommendations which we proposed to continue this year. I am asking the chairmen of these committees, who remain the same as last year, to present their projects and plans of action at this meeting.

"*Physicians' Lien Law.* Since the passing of the Physicians' Lien Law Bill, the Board of Trustees has made the Lien Law Committee, of which Dr. Elmer Peter Weigel is chairman, a Reporting Committee to the Board of Trustees. During the summer this committee has had several meetings and also a joint meeting with the Board of Trustees. A report of the action taken and the recommendations has gone to the County Societies. Dr. Weigel and his members have given careful consideration to the provisions of the bill, and I ask each County Society to coöperate toward the proper functioning of the Lien Law.

The E. R. A. The Emergency Relief Committee, under the chairmanship of Dr. S. T. Snedecor, has been active in handling problems of an acute nature which are constantly arising in its work. I have been invited to sit with this committee during its conferences, and I can assure you their earnest efforts are being spent in the interest of the individual physician.

Woman's Auxiliary. I call your attention to the proposed activities of the Woman's Auxiliary under the leadership of Mrs. Casselman, and the special project of the Speakers' Bureau. May each physician lend his help to Mrs. Casselman's efforts.

"*Allied Medical Professions.* A suggested plan for organization of the Allied Medical Professions of the State of New Jersey was brought before the Board of Trustees, which recommended that a conference be held to discuss matters of common interest to physicians, dentists, nurses, and pharmacists, such as:

- "a. State or national proposals affecting each profession individually or collectively.
- "b. Activities affecting public health and welfare.
- "c. Ethical considerations which directly affect any single profession directly and others indirectly as to principles involved.
- "d. Any proposal involving regulation of such professions.
- "e. Public Health Education.
- "f. Medical economics in its broad general aspect.

"*Medical Bills Committee.* My attention has been called to the Medical Bills Committee, which about twelve years ago was recommended for each County Society. The members of these committees were to be a representative from the physicians, one from the employer or insurance carrier, and one from the State Department of Labor; and the purpose was to consider any disputed medical bill or action. I am informed that Essex and Hudson Counties are the only ones that have such a Committee functioning at the present time. It is my opinion that a committee of this kind is important, but that it should be a state committee and not of each county. I request that a recommendation to this effect may be considered by this body.

"*A. M. A. Conference.* Our Executive Secretary, Dr. Wilkes, accepted an invitation to read a paper before the Annual Conference of Secretaries and Editors of the State Medical Societies, conducted by the American Medical Association in Chicago. His subject was 'The Medical Society of New Jersey Experiments in Furnishing Health Services in the Community'. This is a signal honor to come to our Society.

"*Key Men.* During the year before us, each member of the Welfare Committee will be considered a 'key man' from his local community, to bring us the problems and suggestions of his co-workers and to carry back to them the solutions and recommendations of this Committee. Let coöperation be our slogan for the year."

THE A. M. A. CONFERENCE OF SECRETARIES AND EDITORS

The Executive Secretary, Dr. LeRoy A. Wilkes, upon the request of Dr. Lee, presented the following outline of the impressions gained in Chicago, at the Conference of State Secretaries and Editors called by the A. M. A., at which he gave a paper entitled "The Medical

Society of New Jersey Experiments in Furnishing Community Health Services". Dr. Wilkes said:

"Those who have attended the conference in past years stated that this was the most business-like and most worth-while of the meetings which they had attended. Discussions centered around Medical Economics. The A. M. A. brought out some things about which the State and County Societies had not been sufficiently informed. We were convinced that the A. M. A. has been much more active than the A. M. A. Journal and Bulletin would lead us to believe. Ten principles of Medical Service organization were announced last June and a vast amount of authentic reports on "State Medicine" programs in this country and abroad are made available on request to the A. M. A.

"In the opinion of the A. M. A., it is quite impossible and certainly not advisable to furnish a state or national plan for 'State Medicine', even though such a proposition threatens. It was stated that a great deal of work is being done in Washington which has probably delayed the immediate intention of applying State Medicine. However, it is believed that when Congress meets, plans will be presented for legislative action; and it is the duty of the State Medical Societies to work directly on their national representatives and endeavor to point out to them the impracticability of the suggestions made for the furnishing of a regimented plan of medical practice.

"The discussions of the conference members indicated that the State Societies have been more active in their efforts to find a workable solution to our present economic problems, than is generally known. Various types of experiments are being conducted in State Societies similar to the two projects we have here in New Jersey. There is a very decided interest in the increasing activities which as a result of experience, will suggest what modifications of present practice might be advised rather than propose a new plan which might suggest that we acknowledge that we are not now conducting the best type of service.

"It was the general consensus of opinion that, as a profession, we are delivering the best type of service of which we are capable; and that this type is at least equal to or superior to that given in any other country, though we constantly endeavor to improve it.

"Dr. R. G. Leland, Director of the Bureau of Medical Economics of the A. M. A., gave a résumé of the various types of State Medicine in England and Germany. He attributed England's adoption of Sickness Insurance as a result of the poor law. Health Insurance is misleading and attracts the social workers.

"It was the opinion of those present that we should stand by the professional practice of medicine as we have it now organized, and should improve it by experiments. We should *not* go forward with a plan for State Medicine, as this will show that we too are convinced that the present plan is not working. No one is quite so qualified to pro-

vide a better distribution of services as the medical profession.

"The paper which the Executive Secretary presented at the Conference was very well received. Many members of the Conference took part in the discussion and several requested literature which might be available concerning our New Jersey program. In return, criticisms of the New Jersey plan, from the standpoint of experiments in their own state, were requested of other Society Secretaries.

"The reports of the Journal Editors dealt largely with the number of pages of the State Journals, and their distribution among the various subjects was discussed."

COMMITTEE ON THE UNIFORM MEDICAL PRACTICE ACT

Dr. Samuel Alexander, Chairman of the Committee on the Uniform Medical Practice Act, gave the following report on the activities of the committee:

"The first report submitted was followed by meetings held with the State Board of Medical Examiners, and a supplementary report was made to the House of Delegates Medical Society in June, 1934. The Committee with members of the State Board of Medical Examiners prepared a tentative bill for introduction into the Legislature. Mr. Richmond was engaged to check over this bill so that it will not in any way weaken the present act. It is generally conceded that the New Jersey Licensure Act is at the present time the best in the country. As soon as Mr. Richmond finishes his report, we will call the committee together to introduce the bill into the Legislature, subject to the approval of the Welfare Committee. It is hoped that this will take place at the next legislative session."

Dr. Alexander's report was unanimously accepted.

COMMITTEE ON MEDICAL PRACTICE

Dr. Thomas K. Lewis, Chairman of the Committee on Medical Practice, read the following report:

THE SUB-COMMITTEE ON MEDICAL PRACTICE

"The many favorable comments received relative to the report of the Sub-Committee on Medical Practice, which was presented last June at Atlantic City, have been gratifying. Especially gratifying was the recently received intimation that our Trustees consider the Dispensary Section of the report of sufficient importance to warrant the institution of a state-wide follow-up survey of our hospitals by a special committee. For such survey the following recommendations are submitted:

"1. That a special committee be appointed by the President, sufficiently large to make possible a careful survey of all of the hospitals in the State. The selection of the members of this committee might be facilitated by conference with the various

counselors, and with that member of the Sub-Committee on Medical Practice from the councilor district involved.

"2. That the report on Dispensary Abuses be made the basis for the proposed survey; and that in addition the general scheme of hospital organization shall be investigated with particular reference to the relationship existing between boards of managers, executives staffs, and professional staffs.

"3. That the physician or physicians assigned to the investigation of a given institution shall be selected from a county other than that in which the hospital is located.

"The large part of a day might well be spent in the survey of a single institution, obviously a task of too great magnitude to be undertaken by our sub-committee. Therefore, the recommendation for the appointment of a special body. A relatively large committee will not only expedite the investigation, but will also stimulate a widespread personal interest in this very vital problem.

"New lines of activity to be undertaken by the Sub-Committee on Medical Practice are:

"1. A study of compulsory Industrial Health Insurance; and

"2. Coöperation with the Pharmacal Society in the establishment of a New Jersey Formulary for new and non-official remedies.

"The first activity is inspired by intimations emanating from those close to the present national administration to the effect that legislation involving unemployment insurance and compulsory health insurance is being seriously considered for the near future.

"The second proposed activity will involve not only the proposed New Jersey Formulary, but also a campaign for more widespread use of official remedies which in innumerable instances have been insidiously crowded into oblivion by proprietary salesmanship."

The relation of Dr. Lewis' committee to Dr. Satchwell's Committee on Hospitals and Medical Education was discussed. It was first suggested that probably Dr. Lewis' committee might include a study of this phase of hospital service, in view of his recommendations that the study be made; or Dr. Lewis and Dr. Satchwell might combine their committees to conduct this study. Dr. Lewis himself felt that while his Committee on Medical Practice would gladly assist in the planning of the program of study, it should be conducted under Dr. Satchwell's Committee on Hospitals. Dr. Lewis offered the coöperation of his committee in the conducting of the work. This proposal seemed to meet with general approval; and the formulation of the plans of procedure were left to the Chairmen of these two committees.

Dr. Lewis' report was unanimously accepted.

CONFERENCE OF ALLIED MEDICAL PROFESSIONS

Dr. Thomas K. Lewis also gave a brief report of the meetings of the Conference of Allied Medical Professions which includes the Medical, Dental, Nursing, and Pharmaceutical Associations. The proposals formulated and the By-Laws and Rules of Procedure submitted were discussed and approved by the representatives of the four bodies on September 12, 1934, when a definite organization was formed. Officers were appointed to serve until the Annual Meeting in December, and to get the work under way.

The State Conference of Allied Medical Professions is to be supplemented by similar conferences in each county. The State Conference is to propose and direct activities pertaining to common national and state problems. Each County Conference shall work in coöperation with the State Conference. In local matters, the County Conference shall organize and direct the local program after submitting the program to the State Council for its information and approval. (See page 604.)

COMMITTEE ON WORKMEN'S COMPENSATION

Chairman Lee called upon Dr. Blumberg, in the absence of the Chairman, Dr. D. A. Kraker, who was ill, to report for the Committee on the Workmen's Compensation Act. Dr. Blumberg reported that the committee had met at the Governor's Mansion in Sea Girt during the Summer with Commissioner of Labor, Mr. Toohey, and Commissioner of Institutions and Agencies, Dr. Ellis. Mr. Toohey and Dr. Ellis were favorable to the Medical Society's views and proposals, but nothing was definitely decided. Progress, however, is reported by the committee.

COMMITTEE ON PUBLIC HEALTH

Dr. Stanley Nichols, Chairman of the Committee on Public Health, gave the following report:

The Public Health Committee held a meeting on the 15th of July and has made the following plans to be vigorously prosecuted beginning in September:

1. *School Health.* Our committee has appointed a Special Sub-committee on School Health consisting of Drs. Ireland, Kahrs, Schapiro, Hull and Wilkes, to study the School Health Program, and to meet later with Dr. Lewis' Committee on Medical Practice to consider the question of salaries, programs, appointments, qualifications, and training of school physicians, and the aim and scope of school health programs in different parts of the State.

2. *T. B. Advisory.* Our Public Health Committee has created a special Tuberculosis Advisory Committee consisting of Drs. Pollak, English, Alex-

ander, Newcomb, and Morrow, to work with the committee on the subject of coordinating the physicians of this State with the New Jersey Tuberculosis League in a 1934 and 1935 program.

3. *Pre-school Child.* In accordance with the plans laid down for the past two years by the Committee, the New Jersey Medical Society Pre-school Record Form has been published and is now available at the State Society offices at a cost of one cent each, plus postage. Each County Society, through its Public Health Committee, is urged to coordinate the health agencies of its county for the purpose of getting the pre-school children from age two to age six under the direct supervision of their family physicians, to be seen at least once or twice a year, for the purpose of preparing the infant, over a period of four or five years, mentally and physically for entrance in a healthy condition to school.

The State Committee will assist the County Societies by advisory plans as to how this can be done. The endorsement of the State Department of Health and State Department of Public Instruction will be requested and later that of other co-operating state health agencies. The expectation of the committee is that eventually all schools in New Jersey will request children to present such a card at their first registration at school. This is another step in the development of much needed preventive health service for children in the offices of the doctors of our State Society.

4. *Post-Graduate Education.* The committee has requested, with the approval of State President Ely, that the Committee on Post-Graduate Education create a course in preventive medicine to consist of up-to-date instruction in prenatal, obstetrical care, postnatal, infant care, preschool child care, school health, Manteux and Schick Testing, Tuberculosis Prevention, and annual periodic medical examinations to be made available to each County Society for the purpose of giving each member of our State Society ample opportunity to get the most up-to-date information on the preventive side of medical practice. Dr. Satchwell's committee has approved this course, and information will be forthcoming from his committee.

5. *Diphtheria Immunization and the Public Health Hour.* The committee plans, above all, vigorous prosecution of the diphtheria immunization and vaccination of children between six months and six years in this State. The machinery is now entirely ready. The State Health Department has made free toxoid available in every county in the State. The State Department of Health has given general publicity to the plan, and its officers, and the District Health Officers are giving their cordial help. Most of the County Societies have an ample enrollment of physician members of the County Medical Society to do the work. The State Committee stands ready to help in any possible way; but it is now up to *each County Society* to get together with their health departments and with the assistance of Public Health Nurses, Child Hygiene Nurses, Parent-Teachers Associations, Child Welfare and Health Agencies, and secure the names and addresses of all children between the ages of six months and six years; to

see that, with the help of health departments, nurses and volunteer agencies, these families are *actually canvassed and*, in cases where diphtheria immunization or vaccination is needed that these children brought to the doctors' offices and the work done.

"The responsibility for inaugurating and conducting the immunizations is upon the *Public Health Committee of each County Society*, upon whom devolves the work of securing the vigorous interest and participation of every member of the society. In several counties the work is already under way, but in many its more vigorous prosecution is necessary if we are to show the public and private health agencies of New Jersey that definite medical participation and leadership by our State and County Medical Societies is a reality. The eyes of New Jersey are on this project. The machinery is ready. It needs hard work this next three months and plenty of it to show New Jersey that our State Society meant business when it made the statement that it expected to assume the public health leadership in the State and in each County of the State."

In reply to the suggestion that the promotion of the Public Health Hour by the doctor might appear to be purely commercial, Dr. Nichols said that a large part of the promotion would come from other community agencies, such as the Parent-Teacher's Association. While the present attitude of the P.-T. A. in certain parts of the State may seem to be unco-operative, this problem is one for immediate consideration between the State Public Health Committee and the officers of the State P.-T. A.

Dr. Nichols stated that Dr. Wilkes' experience as National Advisor to the P.-T. A. and Dr. Ireland's experience as State Advisor to the P.-T. A. in New Jersey, should be helpful in persuading the officers of this organization to expand their annual "round-up" of children about to enter school into a continuous "round-up", to urge parents of *all* preschool age children to consult their family physician at least annually in order to prepare the child for school, and to make available records of physical examinations made prior to school entry. This would provide the school authorities with more complete and reliable data than is provided by the school medical inspector alone.

DIPHTHERIA DEATHS

Dr. LeRoy A. Wilkes, Executive Secretary, reported upon a study of diphtheria made in cooperation with the State Department of Health over the past ten years. The study showed diphtheria to be the dominant cause of illness and death caused by the acute communicable diseases.

Dr. Wilkes suggested that much of the

clamor for so-called health insurance apparently comes from social groups and is founded on an emotional rather than factual basis. He suggested that the medical profession of New Jersey follow the example set in Kentucky where they have persuaded the doctors and nurses to attend the conference of social work in that State in order to present factual data, influence their discussions, and to vote in recording an attitude of these social workers favorable to the physicians.

The preschool record card to be kept by New Jersey physicians through the preschool years would present factual data to the schools which is more comprehensive and valuable than that furnished through hurried school inspections as required by law.

The Public Health Committee was giving serious thought to the use of tuberculin for the purpose of immunizing children. He stated that

in Bergen County the services of Dr. Walsh, of Chicago, were engaged every three years to immunize children by the Calmette method.

Dr. Nichols stated that this proposal would be discussed with the Advisory Committee on Tuberculosis appointed by the Public Health Committee of the State Medical Society.

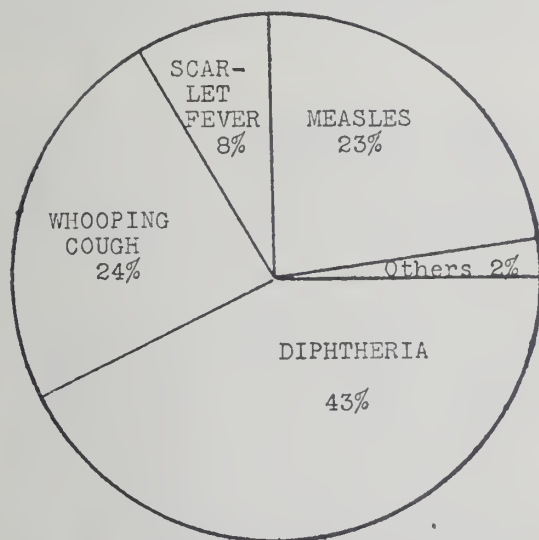
Dr. Ely told of his experience in this regard in Somerset County and disclosed that the motivation for tuberculosis examinations in the schools there came from a commercial x-ray company, who wished primarily to sell its apparatus. Any member learning of such endeavors to impose upon the public should communicate with the Public Health Committee.

It was moved, seconded and carried that Dr. Nichols' report be accepted.

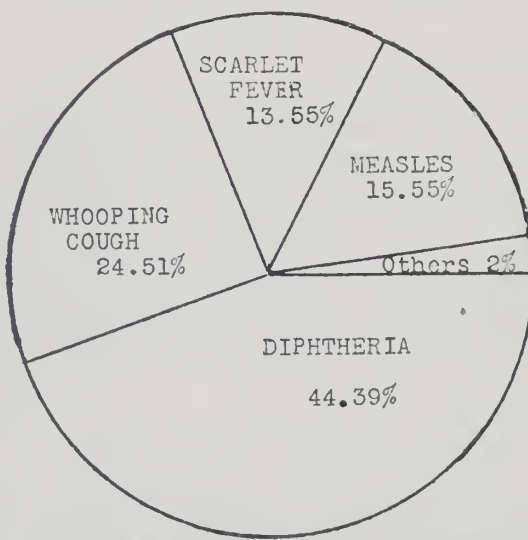
After the consideration of routine business, the committee adjourned at 4:20 p. m.

THE DIPHTHERIA MENACE

FIVE-YEAR PERIOD 1924-1928



FIVE-YEAR PERIOD 1929-1933



Ratio which deaths from specific acute communicable diseases bear to the total number of deaths from all acute communicable diseases in New Jersey for two five-year periods.

The campaign for the prevention of diphtheria has produced remarkable results so that the popular opinion is that the disease is rarely seen, yet it ranks highest among acute communicable diseases as a cause of death, as is shown by the chart for two five-year periods, 1924-1933.

The number of cases of every disease on the chart has been reduced during the last decade; but diphtheria, which is typically a preventable disease, now causes nearly one-half of all deaths of patients in the acute communicable disease group. The failure to reduce the proportion of deaths from diphtheria is not the

result of an increase in the virulence of the disease, or of the impotence of antitoxin as a preventive and curative measure. Responsibility for lowering the mortality rate in diphtheria rests upon two groups of persons:

First, practicing physicians, to perform the service of immunization.

Second, lay health workers—parent-teacher associations, public health nurses, etc.—to urge the people to accept the service.

The "Public Health Hour" is the means offered by The Medical Society of New Jersey for immunizing the large groups of persons who have hitherto not accepted the service.

CONFERENCE OF ALLIED MEDICAL PROFESSIONS

A permanent organization of the physicians, dentists, nurses, and pharmacists of the State of New Jersey was perfected on September 12, 1934, in the executive offices of The Medical Society of the State of New Jersey. The need for such an organization was felt during the legislative session of last Winter and Spring when measures of mutual interest to the members of the four groups were under consideration.

The purpose and method of work of the conference are set forth in the following By-Laws and Rules of Procedure:

BY-LAWS AND RULES OF PROCEDURE

1. NAME

This Conference, composed of representatives of the Medical Society of the State of New Jersey, the New Jersey State Dental Society, the New Jersey Pharmaceutical Association, and the New Jersey State Nurses' Association, is to be known as the Conference of Allied Medical Professions of the State of New Jersey.

2. PURPOSE

The purpose of this Conference is to provide a medium for discussing and taking concerted action on matters of common interest to the licensed physicians, dentists, pharmacists, and nurses of the State of New Jersey.

3. MEMBERSHIP

Each Society holding membership in the Conference shall appoint three delegates who shall be considered the official representatives of the respective Societies until their successors are appointed.

4. MEETINGS

The Conference shall meet at least once a year in the second week of December in the City of Trenton. This meeting shall be known as the annual meeting at which officers are to be elected and reports are to be received from officers and committees. Other meetings may be called by the Chairman or by action of the Conference.

5. OFFICERS

The officers shall consist of a Chairman, a Vice-Chairman and a Secretary-Treasurer.

6. VOTING

In all matters coming before the Conference which may require a vote of the delegates, each Society holding membership in the Conference shall have one vote. On all matters of policy or suggestions and requests for concerted action on the part of the professions

holding membership in the Conference, the vote must be unanimous. One dissenting vote will be sufficient to indicate to the members of the Conference that the question at issue is controversial and cannot receive the united support of the Conference. If the action on a given proposal is not unanimous, the only statement to be made public on the subject shall be to the effect that the Conference has taken no action—thus allowing perfect freedom to any component group to support or oppose any matter which it may consider vital to its own professional group. It should be understood that the object of the Conference is to unite the medical professions in matters on which there is no conflict of opinion and to scrupulously avoid taking action in opposition to the declared policy or action of any component group.

7. ASSESSMENTS

Each Society holding membership in the Conference shall pay to the Secretary-Treasurer an annual assessment of \$25.00. Additional assessments may be levied by unanimous vote of the Conference.

8. ORDER OF BUSINESS

The order of business at meetings of the Conference shall be as follows: Call to order; Communications; Reports of officers; Reports of committees; Unfinished business; New business; Election of officers; Adjournment.

9. LOCAL CONFERENCES

This Conference shall foster the organization of County or District Conferences of physicians, dentists, pharmacists and nurses, patterned upon the scheme of organization of the State Conference. In all matters of State-wide importance the State Conference shall assume the initiative in outlining policies and procedures and District or County Conferences shall follow the leadership of the State Conference. In matters of purely local importance the State Conference shall withhold action and permit the District or County Conferences to function on their own initiative after having advised the State Conference of the action proposed.

10. AMENDMENTS

These By-Laws and Rules of Procedure may be added to or amended by a unanimous vote at the Annual Meeting. Amendments or additions to these rules, involving departure from the previously declared procedure or policy of this Conference shall be referred to the organizations composing the Conference for approval before they are voted upon.

DOCTORS' LIEN LAW

The following open letter from Dr. Elmer Peter Weigel, Chairman of the Committee on the Doctors' Lien Law, which has been sent to each county society, describes the latest developments in the administration of the Law:

At a joint meeting of the Board of Trustees and State Committee on the Doctors' Lien Law held on September 16, 1934, it was definitely decided to accept the fee schedule sent you recently.

There is, however, to be added two introductory paragraphs which shall read as follows:

"This schedule is to apply *only* to such cases as may arise under the Physicians' Lien Law, Senate Bill No. 136—amending the 'Hospital Lien Act', April 30, 1934; and shall in no way influence the charges any physician may make in his private practice."

"In accordance with the Law, the fees herein stated are maximum fees and the charges made for each service shall be *up to* the amount stated."

"It is also suggested that there be added to the Schedule a paragraph stating that the County Society, through its special committee, will be glad to act as a Board of Arbitration to pass on any disputed bill, where it may be desired by the interested parties.

"The Trustees are arranging to secure the services of a competent attorney to assist the county societies, where such help is desired, at the public hearing to accept the fee schedule. If, in the opinion of your committee, it is thought advisable to contact a local attorney also, the action would meet with the approval of the State Committee.

"It is the desire of both the Board of Trustees and the State Committee that each county society make its schedule conform as nearly as possible to the schedule sent you recently. This should be possible since the stated fee is a maximum one and any smaller fee could be charged if, in the doctor's opinion, it was proper. In this way much confusion throughout the state could be avoided."

RADIOLOGICAL SOCIETY OF NORTH AMERICA

Dr. George S. Reitter, East Orange, the New Jersey Councilor of the Radiological Society of North America, announces that the society will hold its next annual meeting at the Hotel Peabody, Memphis, Tennessee, December 3-10, 1934. The medical profession is cordially invited to attend the sessions. Detailed information may be obtained from the Secretary-Treasurer, Dr. Donald S. Childs, 607 Medical Arts Building, Syracuse, N. Y.

Dr. Reitter also calls attention of physicians to two important resolutions which were passed by the American Radium Society on June 12, 1934, at its annual session in Cleveland, Ohio.

The first resolution refers to the frequent necessity of applying maximum doses of radium or x-ray in the effective treatment of cancer. Since physicians are handicapped by the fear of protests from patients on whom an excessive x-ray or radium dermatitis has been produced, the society unanimously adopted the following resolution:

"*Be it resolved*, that we as radiologists recognize that in the treatment of malignant disease, it is often necessary to carry the treatment on to the extent of producing a violent reaction in the surrounding tissues, which may

cause the skin to peel, and blisters to form, in order to give sufficient treatment to overcome the malignant disease. We believe, therefore, that it is justifiable to produce a second degree radiodermatitis when necessary."

The second resolution is lengthy and is a protest against the action of some commercial companies in making diagnoses and suggesting treatments of patients whom they have not seen. One part of the resolution reads:

"*Be it resolved*, that we consider it improper, unethical and detrimental to the science of Radiology and to the good of suffering humanity for commercial laboratories to attempt to give advice or directions as to the use of radium in the case of a patient whom the person giving that advice has not even had the opportunity to examine. In other words, it is just as difficult to give such advice and directions as it would be for a surgeon to give directions for the use of rented surgical instruments so that an untrained physician might attempt an operation. Various commercial companies advertise both in the Journals and through the mails, medical advice for the purpose of making sales or renting radium or radon. This places these corporations in the field of practicing medicine."

BEWARE OF UNKNOWN SOLICITORS!

A physician in a rural section of New Jersey was approached by an agent who showed credentials from a party whose announcement read:

"Medical Research Correlating Bureau, a corporation, Washington, D. C., providing continuous dependable evaluated reports and answers to the questions of the Medical Profession, secured by and through the facilities of the Surgeon General's Library."

The application card read:

"Registration. Please enroll my name as a member of the Medical Research Correlating Bureau for one year. This includes:

"1. Unlimited personal service on request.

"2. Routine evaluated reports sent currently by mail; then printed, indexed and permanently bound, annually.

"3. A compression binder for desk reference.

"For which I agree to pay \$10.00 herewith; and \$10.00 monthly until a total of \$30.00 has been paid."

The application was signed by the physician, and was endorsed:

"Rec'd 10.00, J. J. Sharkey, July 11, 1934."

On August 22, the physician wrote to the headquarters of The Medical Society of New Jersey that he had neither heard anything from the solicitor, nor received any of the services which had been promised.

Dr. Wilkes, Executive Secretary, immediately wrote to the Librarian of the Surgeon General's Office, who replied:

"This is the second request that has come to us for information about this organization and this man. We have never heard of the organization nor of the man, although a statement was made by one of the readers in the library that he was conducting some sort of a research bureau.

"This would appear to be one of the instances which have been not uncommon in late years in which a privately conducted bureau or individual undertakes to supply abstracts from the literature available in this library to the medical profession for a fee. This library is, of course, open to the public and available to all readers, but we do all in our power to discourage a certain type of advertising in which the advertiser implies that he has access to material not available to the public, or is in some way officially connected with the library or the government."

The U. S. Public Health Service and the American Red Cross each wrote that it had no knowledge of the man, although it had inquired at other departments of the government service.

Any physician having a knowledge of the activities of this or a similar agent will confer a favor on his colleagues and the public by informing the Executive Secretary of The Medical Society of New Jersey.

There are, however, reliable organizations which offer bibliographic services in every line of scientific medicine; and information regarding these may be obtained from the Medical Society.

A RADIO ADDRESS

EYE AND EAR DOCTORS AND THE PUBLIC HEALTH

The following radio address is printed as an excellent form to be sponsored by a medical society. It was delivered on September 10, 1934, in Chicago, Illinois, by Dr. Wells P. Eagleton, Newark, N. J., as a part of the program of the sessions of the American Acad-

emy of Ophthalmology and Otolaryngology, of which Dr. Eagleton is now President. The special feature of the address is that it emphasizes the work of an *organization* of physicians in distinction from the activities of *individual* doctors.

There is now in session at the Hotel Sherman in Chicago, the largest society of specialists in the world—The American Academy of Ophthalmology and Otolaryngology—with over 2200 members. Perhaps you do not know what ophthalmology and otolaryngology mean: Ophthalmology means diseases of the eye, and otolaryngology means diseases of the ear, and the throat; and so this is a society of eye, ear, nose, and throat specialists.

The academy has been called a moving university. Thirty-eight years ago, in Kansas City, a small group of men, realizing that so-called "specialists" were becoming too numerous, organized the Academy, its purpose being two-fold: First, to impress a high standard of efficiency on all men who are treating diseases of the eye, ear, nose and throat in America; second, to provide for them each year courses in post-graduate instruction so that those who

had been away from college for some years could have the advantage of a week of intensive study in the specialty in which they are most interested.

The Academy includes a large number of highly trained men who gladly give their services as teachers. The members are divided into groups of from five to twenty for special courses during the mornings.

This year 77 of these courses are being given.

Some years after its establishment, the Academy joined with other representative societies of specialists to found The Board of Ophthalmology and the Board of Otolaryngology. These boards serve without compensation and examine all applicants to decide on their ability to practice as specialists. Every applicant for certification is first privately investigated as to his character and efficiency; if he is then found to be a man of integrity, he is personally examined by the board to see if he can meet the scientific qualification requirements of the board; if he passes these requirements, he is granted a certificate.

The Academy has but one standard—that of character and of education. Remember, before a doctor can become a member of the Academy or be admitted to the boards for examination, he must possess the degree of Doctor of Medicine from a first class medical college and have practiced medicine for at least five years.

These boards—The American Boards of Ophthalmology and of Otolaryngology—held their examinations at the Illinois Eye and Ear Infirmary on Saturday last.

What does this mean? A group of medical men combine to protect the public against incompetence in medical matters, and this protection is unique. No other profession has undertaken what the medical profession has undertaken—to see that it is composed of honorable men who are qualified by sufficient education to practice their specialty.

Do you realize that all of the reforms of the stock exchange were brought about, not by the stock exchange, but by the government insisting that they must reform? Do you realize that certain private bankers and certain so-called leaders of finance were stooping to such questionable practices, selling bonds of insufficient value, that the government had to step in and stop them. Thirty-eight years ago the medical profession said: "We will prevent any such scandal in our profession." That is the difference between being a professional man—a doctor who works for and keeps to the ethics of this profession (and incidentally he makes a good living)—and the man who

works entirely for gain. There are no corners cut in medicine.

Every year this traveling university has a meeting which lasts for five days. This year, its President is Dr. John M. Wheeler, the distinguished head of the Eye Department of the Medical Center in New York City. There is always a guest of honor at its general session, a distinguished member of the profession from a foreign country or from this country. Some years ago it honored Dr. Joseph Beck, of Chicago, because of what he had done for the profession. This year, Professor Dr. Hans Lauber, of Warsaw, Poland, a great eye specialist, is the guest of honor.

Another activity has been the establishment of research departments. Last year \$4000 was expended to encourage doctors to do research work having to do with unsolved problems relating to diseases of the eye, or the ear, nose and throat.

An activity has been that of assisting the library of the Surgeon General of the Army, in Washington. Think of it, here we have a body of specialist doctors who are putting their knowledge and their money at the disposal of the government in times of peace. They are trying to assist the Surgeon General of the Public Health Service in an effort to control the disease called *trachoma*, which was formerly prevalent in southern Illinois, and is still especially prevalent in Egypt.

When I was in Egypt some years ago I saw vast numbers of these cases of "Egyptian sore eyes". This disease, if not properly treated, not only is very painful but often leads to blindness. It is highly contagious; and so we in America have prevented anybody with trachoma from entering the country, in an effort to stamp out this disease. We have almost succeeded in stamping it out in this country, and we are now spreading our efforts in trying to help other countries to eradicate it.

Also we are interested in cases of syphilis of the newborn, and are appropriating money for investigations along this line. Do you know that if a man who is syphilitic is the father of a child, the child is apt to be deaf? No man with active syphilis should be allowed to get married. This movement has been opposed by some who feel that nothing should be done to prevent people having children, no matter if there is a good reason why they should not have them. This association also appropriates money for the study of the prevention and amelioration of deafness. The number of deaf people in the world is very large, and up to a few years ago they had a very hard time of it. Since the establishment

of the *League for the Hard of Hearing*, some of this handicap has been removed.

Wherever this traveling university goes, the medical profession of the community opens its arms wide and places all its resources at the disposal of the Academy. Numerous clinics will be held at the Illinois Eye and Ear Infirmary and elsewhere during the week that the Academy has its Thirty-ninth Annual Session in Chicago.

You ask how all this can be done? It is done because the Academy, like many other medical institutions, is not a money-making affair. Though a comparatively small group, it stands for service to every doctor and to the community. We have a large reserve fund which has been built up from the dues of our members; and though big corporations are failing in dividends, and their stocks depreciating, the financial strength of the Academy has become greater each year. The weakness of all American business, that of special privilege, is absent from the Academy, for it is composed of doctors practicing in eye, ear and nose specialties. Why have the banks and stocks gone to nothing or next to nothing? Be-

cause big bonuses and big salaries were paid! Here is a large organization, made up of independent doctors, which is sounder financially than at any time since its establishment—this in the face of the depression which we have gone through. The Academy is in the business of service to the doctors of American and service to the people of America.

From all this you will understand that these doctors are not gathered just to have a good time. They come together from all parts of the United States and Canada, and work hard at the job of becoming better trained specialists in the eye, and the ear, the nose and throat. They support and foster research which is calculated still further to push back the frontiers of disease and make recognition and cure of established illness much easier. The greatest surgeons and teachers are proud to be asked to appear on the Academy programs and tell what they know for the benefit of the humblest eye and ear doctor in the small towns. No country of the world has witnessed such an effort, unaided by government subsidy or salary, to elevate the standards of special medical practice for the benefit of all.

PARTICIPATION IN THE PUBLIC HEALTH HOUR

The importance of the "Public Health Hour" in medical economics is illustrated by the following letter from Dr. J. Lynn Mahaffy, Director of the Department of Health of New Jersey, addressed to Dr. LeRoy A. Wilkes, Executive Secretary of The Medical Society of New Jersey:

"This department is in receipt of a communication from the health officer of a large village, in which he asks if state biologicals can be made available to the Board of Health to be administered to pre-school age children in the Baby Keep Well Clinics in his borough.

"In his letter the health officer points out that in the past immunizations have been carried on in these stations with materials furnished by the local board of health, the treatments being given by a physician employed by the board. Up to this time this year, under the plan of having physicians immunize children at special hours in their offices, the number of children so treated has decreased. He further points out that because of the decreased budget of the local board of health it is not able this year to supply immunizing materials for local use. He expressed his desire as health officer to encourage parents of young

children to take such children to physicians' offices for immunizations at stated periods with the state materials, and has asked this department if we can advise him which of the physicians in his town have agreed to use the state materials in accordance with rules adopted by the department.

"According to our records up to this morning, none of the thirteen physicians of the village had filed with this department an agreement form to use state materials in accordance with the plan contemplated in the rules. This morning one physician filed such agreement form.

"I am bringing this situation to your attention with the thought that perhaps through your efforts a larger number of physicians in that town may be found willing to carry on immunizations at stated hours and would so advise this department, in order that we in turn could advise the health officer of the village."

It is encouraging that a physician has sent his enrollment for the "Public Health Hour". His example will probably lead others to do likewise.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

OCTOBER

2 Cape May	11 Essex
2 Camden	11 Passaic
2 Hudson	11 Somerset
9 Bergen	12 Atlantic
9 Cumberland	16 Warren
10 Mercer	17 Middlesex
10 Ocean	18 Gloucester
10 Salem	23 Hunterdon
10 Union	24 Monmouth

NOVEMBER

6 Hudson	14 Mercer
6 Camden	14 Ocean
8 Essex	14 Burlington
8 Passaic	15 Gloucester
9 Atlantic	21 Middlesex
13 Bergen	28 Monmouth
13 Sussex	

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular meeting of the Bergen County Medical Society was held September 11th, at the Englewood Hospital. In the absence of the president, Dr. John Irwin was chairman.

The following applications for membership were listed—Regular: Joseph E. Duffy, Westwood; Silas Edwin Robinson, Waldwick. Junior: E. E. Wolfe, West Englewood; G. L. Inge, Englewood; M. M. Kroll, Cresskill; G. B. Barlow, Englewood; Irving Levitas, Westwood.

Dr. David Corn discussed the possible post-graduate course that might be given during the year. Discussion by Doctors Blake, Hitzemann, and Sarla indicated that an intensified course was more valuable.

Dr. J. B. Edwards reported progress on the "Physician's Lien Law". He stated that the committee had gone over the fee schedule but was waiting for action on the part of the State committee. Dr. S. T. Snedecor reported that the Board of Trustees of the State Medical Society would approve the fee schedule originally submitted.

The chairman of the Public Health Committee reported on some of the irregularities discovered in the distribution of the free biologicals by the State Board of Health as follows:

1. Some doctors were not signing for the materials.
2. Some doctors were sending messengers in for the materials.
3. Some doctors were taking materials but not sending the cards of immunization to the State Board of Health.

He also called attention to the fact that there was a tendency for group clinics to use this free material if the doctors did not use it.

The executive secretary stated that, from the public health administrator's point of view it was necessary to have a record of where this material was going.

The meeting was then turned over to Dr. D. B. Hull, who introduced Dr. Samuel M. Beale, Jr., of Sandwich, Mass., who spoke on the use of "Small Doses of Insulin" in many diseases. He recited numerous instances where he felt that small doses of insulin were beneficial and curative, particularly in the degenerative diseases and cancer. He thought that its beneficial action was through removal of

cholesterol and other lipoids from various parts of the body.

"Recent Advances in Cancer" was the subject of the talk by Dr. George T. Pack, Attending Physician of the Memorial Hospital, New York City. He mentioned many of the known factors of irritation as causes of cancer, reiterating his belief that there was no single causative factor. The part played by the hormones of the body as a causative factor was brought out most interestingly by some experiments which he recited.

BURLINGTON COUNTY

H. P. Shipps, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held at the Burlington County Hospital in Mount Holly, at 1 p. m. Wednesday, September 12th.

Dr. S. Emlen Stokes, Chairman of the Section on Specialties, announced the following program:

"Childhood Tuberculosis," by F. Maurice McPhedran, M.D., of the Phipps Institute, Philadelphia, Pa. This was a most interesting and instructive discussion of pulmonary infection in children, and the x-ray plates shown were very illustrative of the conditions discussed.

"Practical Application of Recent Experimental Work on the Circulation and Blood Vessels", by Eugene M. Landis, M.D., of the University Hospital, Philadelphia, Pa.

Following the scientific program there was a lengthy discussion of Emergency Relief Work in Burlington County. Dr. Spencer T. Snedecor, Chairman of the State Advisory Committee to the E. R. A., was present and gave some enlightening information regarding the Emergency Relief Work from a State and National viewpoint. The Society voted to coöperate with the E. R. A. for the coming year.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The *Gloucester County Medical Society* held its regular monthly meeting on the evening of September 20, at the Hotel Pitman, Pitman, with twenty-four members in attendance, as follows: Drs. Fuller G. Sherman, Ralph Moore, Paul M. Pegau, J. Harris Underwood, E. E. Downs, Duncan Campbell, Dorothy Rogers and H. B. Diverty, all of Woodbury; Louis Rittenberg, Mantua; Don Weems, Wenonah; T. M. Galdner and C. L. Ulmer,

Gibbstown; Horace M. Fooder and H. W. Wright, Williamstown; W. P. Chalfant, W. J. Burkett, Thomas L. Sooy, M. F. Lummis and I. W. Knight, Pitman; Samuel F. Ashcraft, Mullica Hill; William Pedrick, Glassboro; B. A. Livengood, Swedesboro; and Ralph K. Hollinshead and E. L. Ristine, of Westville.

The physicians participated in a general discussion on a report made by Dr. H. W. Wright, of Williamstown, on a case of meningitis, and the report of Dr. I. W. Knight, of Pitman, District Health Officer, on the distribution of biologicals as furnished by the State Department of Health.

Delegates to the medical societies of Cumberland, Salem, Burlington and Camden Counties also presented reports on meetings they had attended.

Dr. B. A. Livengood, of Swedesboro, President of the society, announced that the annual social meeting would be held October 18, at the Hotel Pitman.

MIDDLESEX COUNTY

G. W. Hilker, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held at Pfaff's Restaurant, Metuchen, New Jersey, on Wednesday, September 26th, 1934, it having been postponed for a week. Dr. Harry Haywood, Vice-President, presided.

The Secretary, Dr. Edward F. Klein, read communications dealing with the procedure to be followed in indigent cases of social diseases.

A letter from the Pomeroy Surgical Company was read, which explained that the N.R.A. Code has prohibited commissions being given to doctors for referring cases for surgical appliances.

Dr. J. F. Weber, reporting on the Doctors' Lien Law, stated that the schedule of fees for doctors has not been fully decided upon, and until this is done, no action should be taken by the doctors.

Dr. H. W. Nafey spoke of Mr. Peal being engaged for the help of each county medical society in legal questions pertaining to the Doctors' Lien Law.

Dr. George W. Fithian, reporting for the Arbitration Committee of the Emergency Relief Organization, urged that the doctors live up to the letter of the law in these cases. He spoke of the excellent coöperation of the doctors, with but a few exceptions. It was urged that any complaint about the working of the E.R.A. should originate with the doctors and not wait until possibly a lay person would do this for us.

Dr. W. C. Wilentz gave a full report of the total work done by the doctors with the emergency relief cases from February to September, 1934. This showed, among other things, that the physicians of New Brunswick did little of the E.R.A. relief work because much work is referred to clinics by the E.R.A. and the visiting nurses.

Dr. Henry spoke of the great amount of free work that the surgeons were doing without recompense. He felt that recognition of their work should be made by the E.R.A.

It seemed to be the consensus of opinion that the doctors should have a greater degree of su-

pervision over details, such as renewal authorizations for relief cases, which is now in the control of lay workers in the E.R.A.

A committee consisting of Drs. F. M. Hoffman, F. L. Brown and C. I. Silk, were appointed to draw up a formal resolution expressing the sympathy of the Society over the recent deaths of Dr. Swift and Dr. Gutmann.

Dr. L. C. Basset was appointed to represent New Market and Dunellen on the Arbitration Committee. Dr. F. C. Merrill was appointed to the vacancy left by Dr. Gutmann on this committee.

After the meeting was adjourned, a light dinner was served.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

The annual meeting of the *Morris County Medical Society* was held the evening of September 20, 1934, at the New Jersey State Hospital at Grey-stone Park, with President Frost presiding over an attendance of about thirty members and guests.

Treasurer Young rendered a financial report of receipts and disbursements, showing a treasury balance of \$1054.82. The report was unanimously accepted as rendered.

As a member of the Library Committee, Dr. Young reported that during the year the society library maintained at Morristown Library was used fifty-nine times by seventeen physicians; and enumerated the medical journals, health pamphlets, etc., on subscription and on file; and that the subscriptions, maintenance and cost of binding for the year amounted to \$312. The report was unanimously accepted.

Election of officers for the ensuing year resulted in the unanimous selection of the recommendations of the Nominating Committee, as follows: President, Bernard C. McMahon, Morristown; Vice-President, William F. Costello, Dover; Secretary, Albert J. Ward, Morristown; Treasurer, George J. Young, Morristown; Reporter, Marcus A. Curry, Greystone Park; Historian, H. W. Kice, Wharton; Executive Committee, Frank H. Pinckney, Inglis F. Frost, Henry M. Larson; Delegates to State Society, 3 year term, Byron G. Sherman, Inglis F. Frost; Alternates, Stanley Teskey, D. W. Teller; Member of the State Nominating Committee, Bernard C. McMahon.

Dr. Frost, as a member of the Committee on Physicians' Lien Law, reported at length on the conferences and work done, both within the committee and with representatives of state and county societies, and of insurance carriers and the State Bar Association. Reference was made of an impending attack upon the constitutionality of the law. The procedure for completion of forms and the filing of liens was explained with advice that three forms be used, with emphasis on the simplicity of the procedure, and to avoid yielding to the approaches by various companies who are circularizing the profession in this regard; also explaining the appointing of a committee of the society to advise with the court when called upon, on questions arising as to the fairness of the fee charged for service rendered under this law. The schedule

as presented was unanimously adopted as far as it went, but several items were referred back to the committee for more specific inclusion, among them being medical treatment of conditions developing as a result of accident, for the treatment of preëxisting diseases aggravated by accident, administering anesthesia, and mileage allowance when a physician has to travel distances from home.

Dr. Frost, in his retiring address, expressed his pleasure in having been President of the Society for the past year. He recited the activities and meetings held, including the three intra-society clinics held at the Morristown Memorial, All Souls, and Dover General Hospitals which were marked successes. While the society has a membership of about eighty, the attendance at meetings is only about one-half the total membership, with the same members present and the same absent. He urged better attendance, and that the more we put in, the more we receive in return.

Dr. Frost also covered the hospital situation, whose rates are the same now as in 1928, with lack of flexibility such as for "private ward patient" for those who cannot pay the semi-private rate but still wish to pay and select their own physician rather than to be classified as a "ward patient" with its restrictions; and covering a variety of points of professional and economic interest which he believed could be put into effect if given necessary thought and action.

Newly elected President McMahon expressed his appreciation of confidence vested in him, and said that he felt the responsibilities of the numerous problems that will come upon him as President during the coming year; emphasizing that if we realized the tremendous amount of time, thought, study and application Dr. Frost has given as a member of the Committee on Physicians' Lien Law with numerous trips to Trenton, Plainfield, Newark, and elsewhere, and his familiarity with the schedule presented, every member present and absent should feel a greater appreciation of what is being done for the members; and that this also applies with no less force to the members of the Welfare Committee of the society who are required to attend state meetings one Sunday a month from October to May, giving not only of their time, but going to expense to serve us, and also attending the sessions of the Legislature to protect the society from inimical legislation. He also praised the work of the delegates to the State Society. He expressed the appreciation of the members for what these efficient committeemen are doing for us; and also referred to the splendid and tremendous amount of

work of the Secretary in our behalf. He made mention of the assistance to the society in being permitted, through Dr. Curry, to hold meetings with refreshments at Greystone Park. The arranging of attractive programs with prominent speakers, and all that is done by the officers for the interests of the society should be shown by the members by their increased attendance at meetings, both local and State.

After adjournment, refreshments were enjoyed in the cafeteria.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

The first regular Fall meeting of the *Passaic County Medical Society* was held Thursday, September 13th. at the Paterson Health Center, the President, H. F. Willard, presiding.

A motion endorsing the fee schedule submitted by the committee to meet the provisions of the newly passed Physicians' Lien Law was unanimously passed.

The President then appointed a Nominating Committee consisting of: Dr. William A. Dwyer, Dr. John Ryan, Dr. G. E. Tuers.

The meeting was then thrown open for a discussion of the Emergency Relief Administration and its relation to the medical relief.

A great deal of dissatisfaction with the working of the plan was expressed. A summary of the chief complaints are as follows:

Failure of payment for calls made, after authorization by the E. R. A.

Dictation by the E. R. A. and medical advisor as to the number of calls made by the attending physician.

Demand for a diagnosis by the E. R. A., and refusal to pay when the case turns out to be of a chronic nature.

Confusion as to what forms and procedure should be followed by the physician.

General lack of information as to responsible parties concerned with the administration of the E. R. A. and medical relief.

Criticism of the Advisory Committee for not keeping in closer touch with the E. R. A. and protecting the interests of the physicians.

Dr. S. T. Snedecor, from Bergen County, Chairman of State Medical Advisory Committee to the E. R. A., then gave a talk on the functioning of the plan in other counties. He also answered questions pertaining to the plan. He advised closer cooperation and more interest on the part of the physicians.

OBITUARIES

RUSSELL E. TITMAN, M.D.

Dr. Russell E. Titman, a practicing physician of East Orange and a member of The Medical Society of New Jersey, died in the Mountinside Hospital

after an illness of some weeks. Dr. Titman was born in Blairstown in 1890 and graduated from the New York Homeopathic Hospital in 1913, and practiced in East Orange ever since. He was on the staff of the Mountclair Community Hospital.

THE WOMAN'S AUXILIARY

A MEDICAL SOCIETY PROJECT

An organization meeting of the new officers and committee chairmen of the Woman's Auxiliary to The Medical Society of New Jersey was held on Monday, October 8, 1934, in Camden in the Hotel Walt Whitman, with the State President, Mrs. A. J. Casselman, presiding, and over thirty ladies present. The meeting revealed an earnest desire of the ladies to concentrate their activities on a few objectives, and to assist in some project which the Medical Society is already promoting.

Dr. Lancelot Ely, President of The Medical Society of New Jersey, described the project of the State Society in publicity and education. He particularly emphasized the opportunity of the Auxiliary to act as the agent of both the medical societies and the lay health organizations in bringing the two groups together for the common purpose of educating the people to appreciate the purposes and methods of the medical societies.

The unanimous reply of the ladies was that they will do their part just as soon as the medical societies assign a definite project to them.

Dr. Ely replied that the leaders of The Medical Society had devised the following plan of publicity:

1. The appointment of a State Advisory Committee to the Woman's Auxiliary, consisting of Dr. Dan S. Renner, Skillman, Chairman; Dr. Edward W. Sprague, Newark; and Dr. W. K. Campbell, Long Branch.

2. The designation of members of every county society to speak on medical subjects before social and civic organizations, such as Parent-Teachers' Associations.

3. The ladies of the Auxiliary to be the agency for making the speaking appointments for the physicians.

This plan was gratifying to the ladies, for it gave them a definite piece of medical society work for which they are peculiarly well fitted. Physicians have heretofore been handicapped by the absence of a means of approaching the lay organizations; but the members of the Woman's Auxiliary will supply that service, for their social engagements bring them in close contact with the leaders in welfare work.

SOCIETY FOR THE RELIEF OF WIDOWS AND ORPHANS

By MIRIAM S. TEIMER,

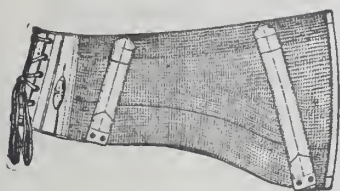
Chairman of the Auxiliary Committee

For over fifty years the Society for the Relief of Widows and Orphans of Medical Men of New Jersey has been of great benefit to the families of deceased physicians. The object of this organization, as stated in its constitution, is "to afford pecuniary aid to the widows and children of its deceased members, and to furnish aid to its members in time of special need or in sickness".

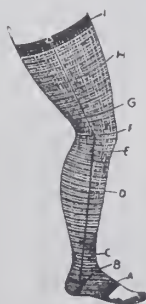
At the death of a physician each member is assessed one dollar if he has been admitted under fifty years of age, and two dollars if admitted between fifty and sixty years of age. Seventy-five per cent of the sum collected is immediately paid to the widow or orphans. The remaining twenty-five per cent is added to the permanent fund. Any member having information of a sick or destitute member may report the case to the standing committee, which may authorize the assistance.

Any member of the medical profession in good standing, and in actual practice in the State of New Jersey is eligible for membership. At a very small cost he may afford assistance to a professional brother in distress or to his family in want.

For the past two years the Woman's Auxiliary of the State has conducted a membership drive for this organization. The Chairman appointed for this work was most earnest in carrying the message of the society to the various County Auxiliaries throughout the state, and prevailed upon each County Chairman to communicate with physicians who have not joined the organization. We feel that this is real work for the wives of physicians. During the coming year each County Auxiliary will have a Chairman in charge of this work in her county, and concise information for prospective members may be obtained from her.



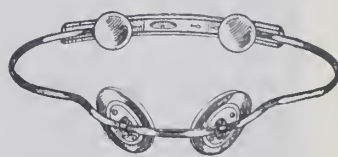
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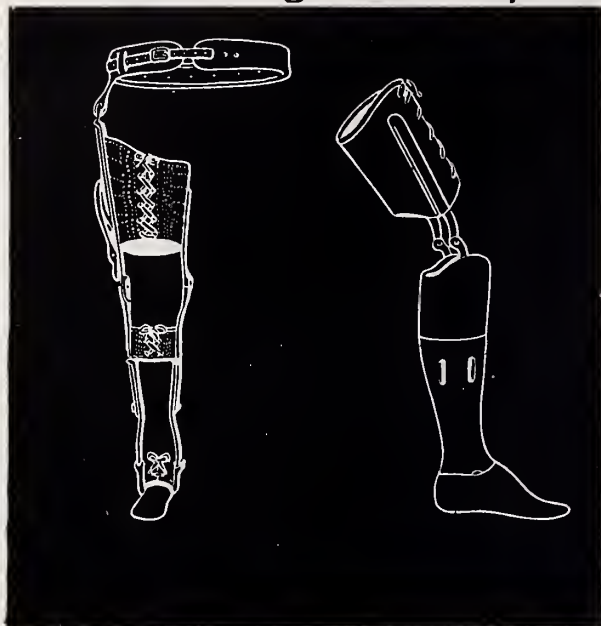
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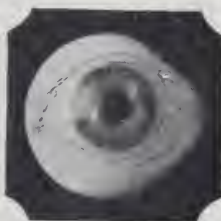
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NOVEMBER, 1934

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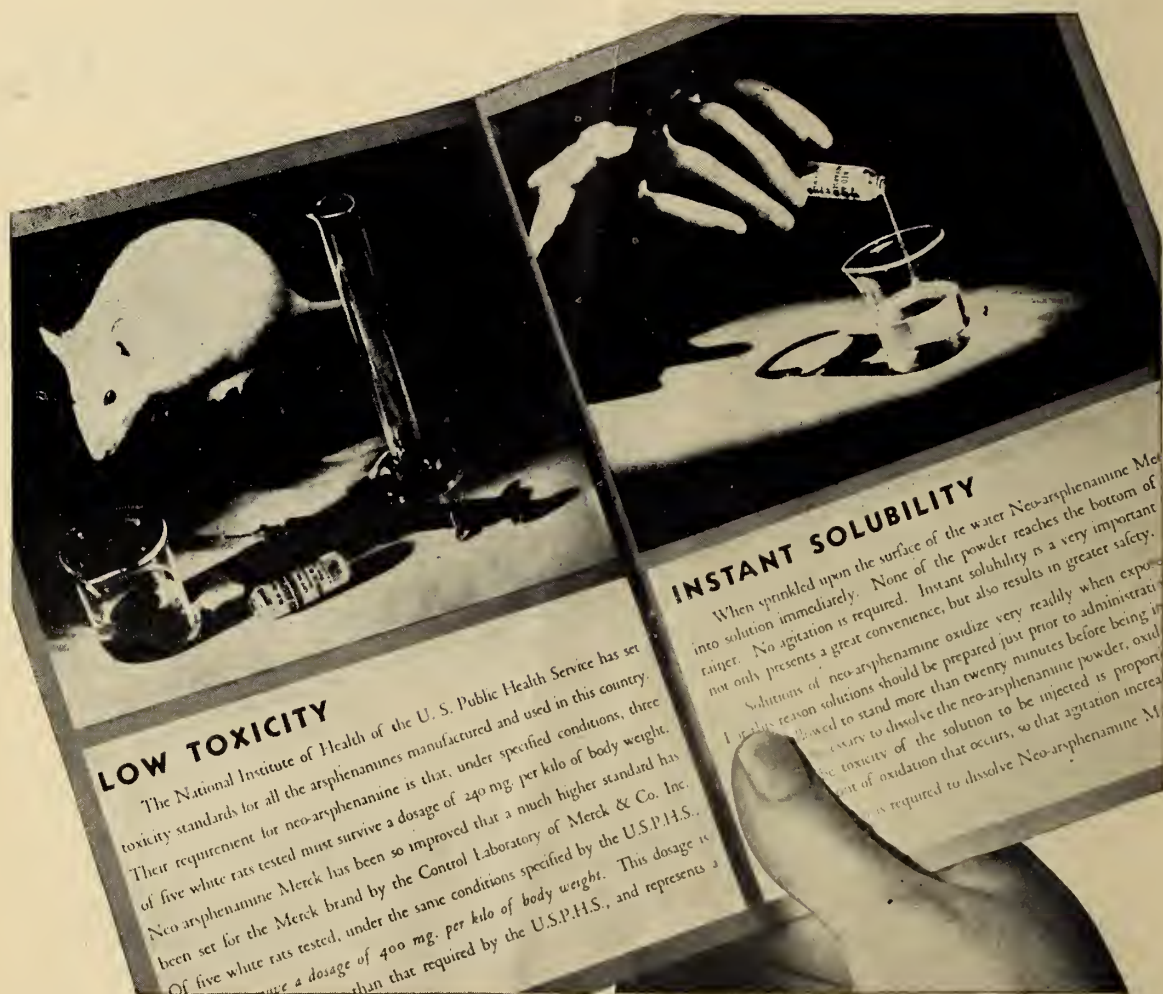
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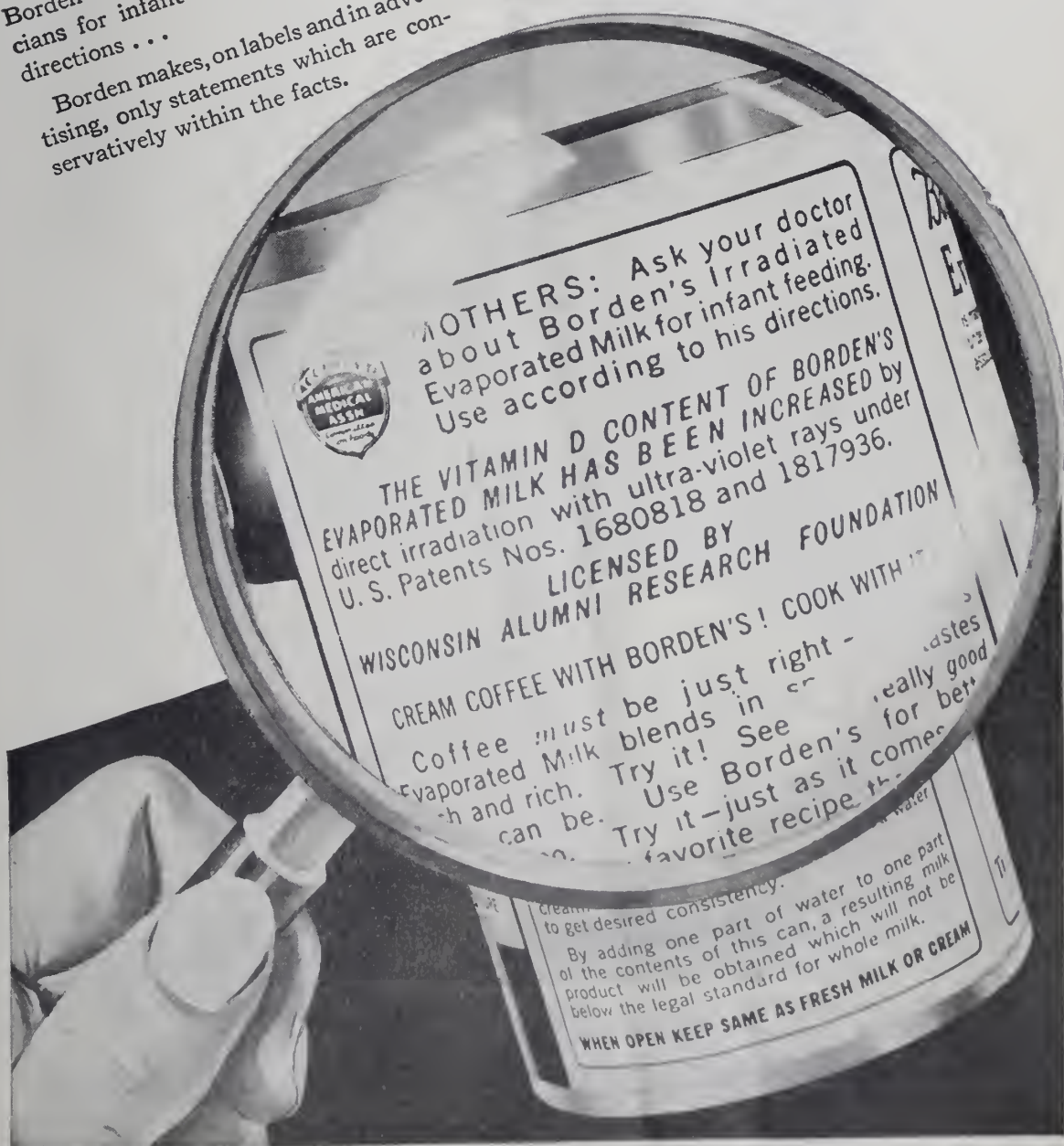
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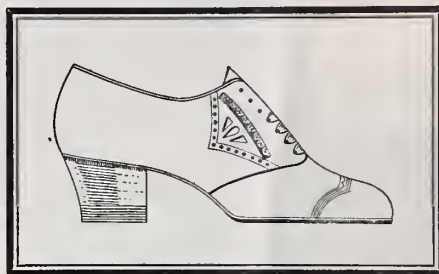
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Relative Values of Carbohydrates Employed in Infant Feeding

Continued down from 1911

1916

"For the addition of sugar, I usually use dextrin-maltose, which does not easily cause fermentation."—*L. L. Meininger: Use of Eiweissmilch, Arch. Pediat., 33:529-532, July, 1916.*

1916

In the treatment of marasmus, "Three per cent of malt sugar should be administered from the first, afterwards running up to as high a per cent as the child will take."—*L. T. Royster: A Handbook of Infant Feeding, C. V. Mosby Co., St. Louis, 1916, p. 100.*

1916

"Least irritating of all sugars, and more readily digested and quickly absorbed, is maltose."—*H. Loevenburg: A Practical Treatise on Infant Feeding and Allied Topics, F. A. Davis Co., Phila., 1916, p. 73.*

1916

"Dextrin-maltose is valuable in cases where intestinal disturbances are due to fermentation of milk sugar."

"Treatment (of sugar intoxication) consists in eliminating the latter (whey salts) as well as the sugars from the diet temporarily, and when the symptoms have subsided, a different sugar in proper proportion should be cautiously added; maltose and dextrin are preferable, because they are not apt to produce fermentation, while milk sugar is prone to set up fever and diarrhea."—*E. E. Graham: Diseases of Children, Lea & Febiger, Phila., 1916, pp. 179-201.*

1917

"For children who are not gaining on a normal formula with a sufficient amount of sugar of milk, or children who vomit when sugar of milk is fed, or who are constipated, the use of maltose instead of lactose often gives most satisfactory results. This is readily accomplished by substituting for the 4 or 5 per cent. of added sugar of milk an equal amount of dextrin-maltose or malted milk, which latter gives, in addition to the maltose, some protein food and an insignificant amount of fat. In many cases children who have failed to gain on other food will immediately show a marked gain as soon as this change is made."—*R. G. Freeman: Elements of Pediatrics. Macmillan Co., New York, 1917, pp. 191 and 192.*

1917

"The carbohydrates most used in infant feeding are the three soluble sugars and starch. The three soluble sugars are lactose, or milk sugar, maltose, or malt sugar, and saccharose, or cane sugar. Maltose is not used in its pure form, on account of its cost. The various commercial preparations of maltose are combinations of maltose with various dextrins, but as in digestion dextrin is converted into maltose, the chemistry is practically the same."

"The sugar which is not absorbed is broken down by the bacteria of the intestine into a great variety of fermentation products, among them being lactic, butyric, acetic, and succinic acids."

"Another effect of the excessive fermentation which results from a relative excess of carbohydrate in the food, is the formation of an excessive amount of gas. This may cause abdominal distention, and, extending backward, it may carry irritating acid products into the stomach, and thus cause vomiting."

"Lactose is the sugar most likely to produce acute symptoms. The stools are practically always green and very irritating. Flatulence and colic are less prominent."

"The maltose-dextrin preparations rarely produce acute exacerbations."—*C. H. Dunn: The Hygienic and Medical Treatment of Children, Southworth Co., Troy, New York, 1917, pp. 423, 424, 425, 428.*

1918

"The sugars in the foods are milk sugar which is found in mother's milk as well as in cow's milk, cane sugar and malt sugar. Though milk sugar is a natural ingredient of milk it is not well borne by babies when added to their food; they digest cane sugar, the ordinary granulated sugar, much better; malt sugar is the easiest digested by babies."—*C. G. Leo-Wolf: Nursing in Diseases of Children, C. V. Mosby Co., St. Louis, 1918, p. 24.*

1918

"Maltose (malt sugar) has the advantage of being very easily digested; when part of the sugar given is maltose, many children gain more rapidly in weight than when only milk sugar or cane sugar is used."—*L. E. Holt: The Care and Feeding of Children, D. Appleton & Co., New York, 1918, p. 66.*

1919

"In the administration of protein milk with its large protein content, by adding to it sugar which is not easily fermented (dextrin-

maltose), we produce, instead of pathologic fermentation, a condition of putrefaction which changes the acidity of the intestinal contents to alkalinity, the peristalsis is decreased, the intestinal contents pass slowly through the large intestines with absorption of fluid and excretion of calcium and magnesium salts. These minerals unite with fatty acids to form the typical fat-soap-clay-colored constipated stools characteristic of protein milk feeding, and it is at this point that dextrin-maltose should be added to the food."

"The majority of the cases were kept on protein milk for a period varying from three to four weeks, and, in many instances, contrary to the usual opinion, we were able to keep the children on protein milk plus starch and dextrin-maltose, sufficient for their caloric needs for a period of several months, in each instance accompanied by a substantial gain in weight and normal increase in vigor and tissue turgor with comparative freedom from digestive symptoms."—*A. Brown and I. F. MacLachlan: Protein milk powder, Canad. M. A. J., 9:528-537, June, 1919.*

1920

"There are three sugars commonly employed in infant feeding: (1) malt sugar or dextrin-maltose, (2) cane sugar, and (3) milk sugar. Malt sugar is the most easily digested and assimilated, cane sugar next and sugar of milk the least so."—*L. O. Frech: The caloric method of artificial feeding in normal babies, Illinois M. J., 38:484-488, Dec. 1920.*

1920

Regarding treatment in disturbed metabolic balance in infants, "The one carbohydrate which seems to give the most satisfactory results in these cases is malt sugar."—*H. Seybert: Disturbed metabolic balance in infancy, Hahnemann, Monthly, pp. 379-382, June, 1920.*

1921

"Next to woman's milk is cow's milk in simple modification with water and sugar in proper proportions and amount according to the age of the child. Milk Sugar is the most expensive and least satisfactory sugar. Dextrin-Maltose is the best sugar."—*A. A. Shawkey: Infant foods and infant feeding, West Virginia M. J., 15:284-287, Feb. 1921.*

1921

With reference to hypotrophy, "In mild cases, the addition of dextrin-maltose instead of cane or milk sugar may be sufficient to obtain a gain in weight."—*C. Herman: The treatment of nutritional disorders in artificially fed infants, New York M. J., 114:158-160, Aug. 1921.*

1921

"Maltose and dextrin compounds are acceptable to the infant's digestion in relatively larger quantities. They are not as sweet as cane sugar. They are of practical value when larger amounts of cane sugar are not well borne."

"The so-called 'Mead's Dextrin maltose with Potassium Bicarbonate' is laxative, and in the presence of a stationary weight may be given in larger amounts."—*F. W. Ferguson: A method for the modification of cow's milk, Journal-Lancet, 41:628-629, Dec. 1, 1921.*

1921

For cases of fermentative diarrhea, "... the ideal plan of treatment would be to give a food which is low in sugar (the food which that group of organisms thrive on) and high in protein. Calcium caseinate milk accomplishes this purpose. In our series of cases, we found it was necessary to use the casein calcium for from 5-8 days; we then stopped it and added dextrin-maltose to the formula."—*A. G. DeSanctis and L. V. Pailer: The value of calcium caseinate milk in fermentative diarrhea, Arch. Pediat., 38:233-236, April, 1921.*

1922

In the treatment of diarrhea, "The sugar is added gradually as conditions admit, some sugar other than milk sugar or cane sugar being used, preferably dextrin and maltose."—*H. E. Small: Diarrhoea in bottle-fed infants, J. Maine M. A., 12:154-155, Jun. 1922.*

1922

"The use of other soluble carbohydrates other than lactose for milk modifications are very good. Some believe the addition of dextrin or dextrin-maltose makes the casein curd softer and easier to digest. This is questioned, but all agree that in cases of malnutrition, where the patient is intolerant to lactose and cannot get the benefit needed from the fat in the diet that the dextrin-maltose is invaluable as it is the easiest sugar to digest, and can be immediately used for energy production without undergoing further change."—*L. G. Padfield: Remarks on infant feeding, J. Kansas M. S., 28:37-41, April, 1922.*

Continued down to 1934

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UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



EDITOR OF
THE JOURNAL
FRANK OVERTON, M.D., Dr. P.H.

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EXECUTIVE SECRETARY—LEROY A. WILKES, M.D.

Each member of the State Society is entitled to receive a copy of THE JOURNAL every month. Any member failing to receive the paper should notify the Editor. Please send notice of change of address promptly.

Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.

Officers, Trustees, Councilors and Committees of the Society are listed on page xx of the Advertising Section.

VOL. XXXI, No. 11

NOVEMBER, 1934

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EDITORIALS

The Conference of Secretaries and Reporters

The Conference of County Secretaries and Reporters, which is reported on page 645 of this Journal, was conducted on the plan that the local representatives should direct it from the time of devising the program to the last minute of the conversations. The State officers were present as fellow-workers striving to carry out the policies adopted by the county representatives in the House of Delegates. The officers outlined the basic principles on which the work of the central office is conducted. The central office performs the functions of a clearing house in which reports are received and classified, and information and advice are relayed back to the local groups. The relation of the central office to the secretaries and reporters is coöperative and advisory in conformity to the representative form of the organization of the societies of the counties and the State. The State Society representatives are ready to receive suggestions from any county society, and to relay them to all the others. The conference afforded the secretaries and reporters the opportunity to discuss their problems and aspirations freely and

confidentially. Mutual confidence is the best basis for efficiency in any organization.

The State officers outlined some definite plans for needed extensions of working facilities in not only the central headquarters, but also in the offices of the local secretaries and reporters, because of the constantly increasing scope of the public relations of physicians. The increased office facilities are especially necessary in the county societies, in order that their officers may perform their constantly increasing duties with efficiency and promptness.

While the discussions at the conference were of great interest and value, it has not seemed wise to print the stenographic report of the proceedings, both because of their length, and also because the opinions, especially those of the secretaries and reporters, were given extempore, and lose their force when they are quoted without reference to the occasion under which they are spoken.

The conference was eminently *practical*, and will promote the morale of all the workers in carrying out the projects of the medical profession.

Practicing at Summer Resorts

A summer resort is an attractive field of practice to city physicians who thereby earn the cost of their vacations, but at the expense of the local physicians. An example of this practice may be seen in Hamilton County, New York, in the heart of the Adirondack Mountains. The County has a permanent population of three or four thousand who are served by about three local physicians from October to June, when conditions of travel are extremely bad; and by twenty-five city doctors during the summer when the population is 25,000 and a ten-mile ride is a pleasure trip amid beautiful scenery. An exasperating feature of the practice is that the local people "save up" their ills so that they may consult the city "specialists".

A somewhat different condition prevails in the summer resorts of the New Jersey coast where the permanent population is sufficient to support an adequate quota of physicians unless city physicians appropriate a large proportion of not only transient patients, but also of the permanent population. This condition has impelled the Monmouth County Medical Society to send the following letter to the Board of Trustees of The Medical Society of New Jersey:

"The Executive Committee of the Monmouth County Medical Society respectfully draws the attention of the Board of Trustees to a situation which has been in existence in our county for several years and about which we have been hesitant to protest. However, during the past summer the condition has become so evident that we feel a solution should be sought during the winter months.

"We are referring to the practice of New York and Philadelphia physicians maintaining summer offices in our county. These men may or may not be licensed to practice medicine in the State of New Jersey. In either case, we feel it is an injustice for these men to arrive in our communities, ostensibly for a vacation period, and then proceed to practice medicine, utilizing our hospitals, nursing staffs, laboratories, and other facilities.

"We also feel that it is hardly the proper thing for doctors in the larger cities of New Jersey to remove their offices to the vacation centers during the summer months, as they are imposing on the local physician, who must of necessity depend on the summer for a marked increase in his business in order to make it possible for him to subsist during the winter. We also believe this situation exists in other summer resorts outside of Monmouth County.

"We cannot draw this matter to your attention too forcibly; and we would urge that a discussion be opened in a meeting of the Board of Trustees at the earliest opportunity. We would appreciate it if you would notify us of any procedure or conclusion arrived at by the Board.

"D. F. FEATHERSTON,
Secretary-Treasurer."

The Board of Trustees considered the letter at its meeting on October 28, and came to the conclusion that neither the Board nor the State Society is able to institute corrective measures when the out-of-state practitioners hold New Jersey licenses. If they do not hold New Jersey licenses, action against them lies with the State Board of Medical Examiners. However, it was the opinion of the Board that the letter should be presented editorially in The Journal, in order to call attention to the injustice imposed upon our fellow physicians at seaside resorts.

Planning for Security

The socialization of medicine is being promoted by welfare workers, and not by practicing physicians; yet physicians constitute the group that will be the most vitally concerned in a change in the method of delivery of medical services. Physicians are ready to give advice as to the practicality or desirability of the socialized form of practice as compared with the present system, but the amount of information which they have issued on this subject is small compared with the great quantity of

propaganda put out by welfare and social workers.

In order that physicians may exert the amount of influence which is expected of them, they must become proficient along two lines:

1. Knowing the viewpoint of the social workers.
2. Formulating the viewpoint of the medical profession and presenting it to the social workers.

Physicians can accomplish these two objectives best by mingling with the other groups and engaging in friendly conversations with them. An opportunity to do this is afforded by the annual meeting of the *New Jersey Conference of Social Workers* which will be held in the Berkeley-Carteret Hotel, Asbury Park, December 6-8, 1934. Physicians are cordially invited to attend the conference and to take part in the deliberations. The officers of The Medical Society of New Jersey are arranging for representatives who shall attend the sessions and express the view of the medical profession as the occasion arises.

The comprehensive subject of the Conference is *Planning for Security*. The program of the Conference is devoted to economic, political, and social processes which influence the social security of the people. It emphasizes the "Tragedy of an Unplanned Society", and aims to set forth the part to be taken by the specialized social agencies, of which the medical profession is a unit. Security in health will be included in the subjects to be discussed at the Conference.

The plan of the Conference is that general sessions will be held on Friday and Saturday

mornings, each to be followed by discussions in groups of thirty persons. Physicians will have the opportunity to speak to the groups and explain the attitude of the medical profession toward the provisions for security in regard to health.

Every plan of social work has its health contacts, and health problems continually confront social workers who sometimes do not realize their own limitations of knowledge and ability in medical relations. The plans of the medical profession is that each county medical society shall be the health advisors to all social groups within its area. An evident line of work of physicians is to educate the social workers to consult the representatives of the county medical societies in all problems that involve health service. This objective will be promoted by the presence of a considerable number of physicians at the sessions of the Conference of Social Work, and their active participation in the discussions. Not only will the presence of the physicians be an indication of good will and of coöperation with the lay groups, but their sincere words of advice will guide the social workers in dealing with the medical phases of their work.

A Model Tumor Clinic

The usual meaning of a clinic is that it is a medical service given by an organized group of physicians to a group of patients. Physicians ascribe degrees of fitness in clinics according to their conformity to standards of medical practice. A clinic that has the approval of physicians is the *Tumor Clinic* of Nassau County, New York, which is conducted under the joint auspices of the County Committee of the American Society for the Control of Cancer, and the Nassau County Medical Society which has about 250 members. The Chairman of the Joint Committee is a Past President of the Nassau County Medical Society, and its Secretary-Manager is the full-time lay secretary of the medical society.

The services of the clinic are given in the county hospital, which provides ordinary measures in diagnosis and therapeutics. The service

is in charge of a full-time medical director who is advised by consultants from the Memorial Hospital of New York City. Special services, such as surgical and bacteriological, are given by local physicians appointed from the three principal hospitals of the County. Patients are admitted only on the written applications of their family physicians, who are also kept informed of the progress of the cases. The service is one of close coöperation with the medical profession.

The hospital was built and equipped with donated funds; but its operating expenses are met by receipts from the patients or the county Welfare Department. There is coöperation among all the groups concerned with the clinic—patients, doctors, welfare workers, and the people generally.

During the year and a half that the clinic

has been in operation, 567 patients have been treated, of whom 473 were admitted on the applications of 179 physicians and three dentists, and 84 were transferred from 12 hospitals.

The satisfaction and interest of physicians with the service is shown by an average attendance of 25 doctors at a conference and discussion of cases that is conducted at the hospital on one afternoon a week.

The satisfaction of the patients is demonstrated by their willingness to attend meetings of medical societies and show the results of their treatments.

The satisfaction of the families and friends of the patients is demonstrated by the record of 70 per cent of autopsies on the 63 deaths which have occurred among the patients.

The Nassau County Tumor Clinic has demonstrated the soundness and practicability of three principles which are sometimes disputed.

1. It is possible to secure the sincere and intelligent coöperation of lay groups and voluntary health agencies with the practicing physicians, when they are represented by the county medical society.

2. Clinics for the care of the sick may be conducted without interfering with the professional or financial rights of the practicing physicians of a community.

3. If the lay group will work to assist the professional group rather than compete with it, the doctors will give their hearty support to the lay group.

Diphtheria Death Rates

There is a possibility of a misunderstanding of the diagram of diphtheria fatalities on page 603, of the October issue of this Journal.

A death rate involves a comparison of two sets of figures. The fundamental figure is the actual number of deaths from a certain disease or condition in a given group or community.

The figure for comparison may indicate any one of a number of conditions of which three examples may be cited.

1. The number of deaths from a given cause may be compared with the *population*. This rate may properly be called the "death rate". The October Public Health News, page 229, gives a table of death rates showing that in the whole State of New Jersey in 1923 the deaths from diphtheria numbered 1.4 persons in each 10,000 of population. In 1933 the diphtheria death rate had fallen to 0.12 per 10,000 inhabitants—one-twelfth of the rate of ten years previously.

2. The number of deaths from a given disease may be compared with the number of those *who have the disease*, giving what is properly called the "fatality rate". Using the same table as in the first example, a simple compilation shows that in 1923 7.7 per cent of those who had diphtheria in New Jersey

died; while in 1933 the percentage was 4.1—a great drop in the fatality rate among those who had diphtheria.

3. The number of deaths from a given disease may be compared with the number of deaths from a whole group of diseases to which the particular disease belongs, thus giving what is called a "percentage rate". The group that is usually called *acute communicable diseases* includes diphtheria, scarlet fever, measles, and whooping cough, and in addition, a list of others running from chickenpox, to smallpox and typhoid fever.

During the five-year period, 1924-1928, the total number of deaths from the diseases in this group was 4,471, of which 43 per cent were caused by diphtheria.

In the five-year period 1929-1933, the total number of deaths from the group of acute communicable diseases was 2,307, of which diphtheria caused 44.39 per cent—an actual increase over the percentage of the previous five-year period.

Diphtheria is today the leading cause of death in the group called acute communicable diseases of childhood, its percentage (44.39) being nearly double that of the next highest, whooping cough, with 24.51 per cent, and

triple that of the third on the list, measles, with 15.55 per cent.

The prevention of diphtheria is in the hands of physicians through the administration of toxoid for immunization during the first two years of life. The very great drop in the

actual number of diphtheria cases during the last three years reflects the activity of physicians in giving the immunizations, and is an encouragement to all practitioners to enter heartily into the *Public Health Hour* project of The Medical Society of New Jersey.

Introducing Medical Bills in the Legislature

The Committee on Legislation of the Medical Society of New Jersey requests physicians to consult the committee before they prepare medical bills for introduction in the Legislature. This request is made for the immediate purpose of adapting the provisions of the proposed bills to those of other medical bills which will be introduced, thereby avoiding conflicts and contraindications of medical opinion. Any exhibition of disagreement among physicians creates a bad impression on the lawmakers and tends to discredit physicians generally. One object of the Committee on Legislation is to afford the opportunity to all medical groups to express their opinions and to join in unified requests to the Legislature. Physicians have influence in legislation in direct proportion to their unanimity of opinion and action.

The Committee on Legislation has won the

respect of the members of the Legislature by its demonstration that it is receiving the active support of the practicing physicians throughout the state. The source of the power of the committee in securing wise legislation is its facilities for informing every Senator and Representative of the opinion of his physician constituents regarding medical bills. Both the legislators and the practicing physicians will be annoyed by attempts to pass a dozen or more bills; but concentration of their efforts on two or three of the more important bills aids in securing their passage.

The Committee on Legislation will welcome suggestions for medical legislation; but it asks that the proposals be made *early* so that the committee may outline both a *program* for legislation, and also a *method* for securing the enactment of the bills which it supports and the defeat of those which the medical profession opposes.

Legal Problems

Medical societies deal with questions of law so seldom that in their inexperience they are likely to make serious errors either of commission or omission. This is especially true when the discipline or expulsion of a member is under consideration.

The New York dailies of October 18th contained an account of an order of the Supreme Court reinstating a member on whom the Medical Society of the County of New York had imposed the penalty of suspension of one year. The charge against the doctor was that he had inserted an advertisement of his sanatorium on the menu cards of the diners of a Florida railroad. The several steps in the proceedings against the doctor are described in

the September 29th issue of the *New York Medical Week*, the organ of the New York County Medical Society. The Medical Society of the State of New York, to whom the defendant doctor had appealed, sustained the sentence imposed by the County Society. But the judge reversed the action of the Medical Societies and reinstated the member on the ground that the defendant had no part in the unethical publicity with which he was charged. The specific ground of the judge's action was that two railroad officials testified before him that they had prepared and inserted the advertisement without the knowledge of the defendant doctor.

The legal principles involved in the suit are

simple and easily understood. A medical society may impose a sentence of suspension or expulsion on a member for a violation of a specific item of its written code of ethics, one of which is that a physician may not advertise himself.

The procedure of discipline and expulsion is that of a law court and involves the following essentials:

1. A definite charge served upon the defendant member.

2. A trial before the censors sitting as judges with the defendant permitted to be present and defend himself.

3. Evidence sufficient to sustain the charges.

The menu cards bearing the doctor's advertisement were uncontroverted evidence of an unethical practice, but the censors probably

did not consider their authorship. The burden of proof was upon the prosecution to prove that the doctor himself caused the advertisements to be issued. Since this proof had not been produced before the censors, while direct testimony to the contrary was given by railroad officials on the appeal, the reversal of the decision of the County Society was inevitable.

A course that is often followed in a trial involving expulsion is that the accused member resigns in order to avoid the trouble, expense, and notoriety of a trial. However, the only certain course for a county society to take in a disciplinary action is to make sure that the evidence is entirely convincing according to a strictly legal point of view.

Automobile Insurance

The State Medical plan of automobile insurance is saving each participating member much more than his annual dues in his county or state societies. The project has been developed under a standing committee of which Dr. Frank W. Pinneo, of Newark, is Chairman. Dr. Pinneo in his annual report to the House of Delegates on June 5, 1934 (*Journal*, May, 1934, page 274), called attention to the plan and to the friendly service rendered to the insured in addition to the minimum that is required by the contract.

The automobile insurance plan is similar to that of Medical Defense. The Medical Society itself is not obligated financially in any way, but each member deals with the insurance company individually under conditions which have been agreed upon by the Medical Society and the company. A certificate of membership in a county medical society makes a physician eligible for the insurance. The insurance company attends to the details of securing the applications, issuing the policies, collecting the premiums and settling the claims. The low cost of the insurance is possible be-

cause physicians constitute a special group in whom intelligence and good judgment are predominant characteristics.

When the Committee on Insurance prepared its annual report in April, 1934, about one-third its members had insured their automobiles under the State Society plan. In June the proportion of the insured had increased to one-half the membership; and by October 1st, 60 per cent of the members had taken out this automobile insurance.

Many physicians who have been dilatory in placing automobile insurance under the plan of the Medical Society have complained that they were not aware of the plan. The fact is that every member not insured had received several letters from the Way Agency, Inc., which is authorized to handle the insurance. Possibly, the doctors supposed the letters were ordinary solicitations of a commercial firm.

Any member who wishes to participate in the automobile insurance project of the Medical Society of New Jersey may obtain the address of the Way Agency from the advertising pages of *The Journal*.

ORIGINAL ARTICLES

PRENATAL CARE

By ARTHUR W. BINGHAM, M.D., F.A.C.S., East Orange, N. J.

Read before the Burlington County Medical Society, May 9, 1934

At one time, pregnancy was considered a physiological process which should be followed by a normal completion and there was thought to be no necessity for the pregnant woman to place herself in the care of the obstetrician until a short time before her expected confinement. These views have changed and patients are becoming educated to the fact that, while normal pregnancy is physiological, the possibility of pathological conditions occurring is so great that the pregnant patient can safeguard her pregnancy only by placing herself in the hands of her physician as early as possible.

Prenatal care has been developed to such an extent that today it is one of the most important procedures in the advancement of maternal welfare. Prenatal care can be carried out easily by any physician interested in obstetrics; and the patients, as a rule, are anxious to follow his directions. Yet, even today, there are thousands of patients who get only very superficial prenatal care.

In maternal welfare work prenatal care is usually one of the first public health procedures to be organized, and it will always receive the support of any community. The physician is rare who cannot improve the prenatal care which he gives to his patients; and organized prenatal care never reaches perfection in any community.

SCOPE OF PRENATAL CARE

A brief family and personal history is first obtained including:

History of tuberculosis, scarlet fever, nephritis, or other diseases.

Previous pregnancies (if any).

Miscarriages (if any).

Character of previous labors (if any).

A patient who has had a number of miscarriages should have a Wassermann, which if

positive, should demand proper treatment. If negative, instructions should be given regarding the necessity of keeping quiet, etc., for many miscarriages are caused by the patient's ignorance of how to care for herself.

STILL BIRTHS

The history of a stillbirth without a difficult delivery should call for a Wassermann, unless a definite cause of death can be found. If Wassermann is positive, proper treatment should be given. If negative, protiodide of mercury with charcoal is almost a specific for patients who have had repeated stillbirths. It apparently improves the condition of the placenta. One-quarter of a grain is given twice daily, always after eating. The results are most gratifying.

A history of hemorrhage in previous cases is of great value in placing the physician on guard. Often the physician is apt to consider these details too lightly, thinking that these complications may not be likely to occur again.

The age of the patient, while not such an important factor as once considered, may at times make quite a difference in the treatment of the case. For instance, in a doubtful case, one would be much more likely to do a cesarean on a patient over forty years of age than if she were twenty-five.

SIZE OF PELVIS

Pelvic measurements should be taken; and while not an absolute guide, they are of great importance in some cases. It is difficult to estimate always the thickness of the pelvic bones correctly. A patient may have a fair sized pelvis, but on account of heavy bones may have great difficulty in labor. Another patient with a deformity apparently sufficiently marked to require a cesarean will deliver herself if the baby is small. It is the relative size

of the pelvis and the head with which we are most concerned; and it is only by watching a patient through the later months of pregnancy that any fairly accurate opinion may be formed. An x-ray of the pelvis is sometimes of value, but not essential.

GENERAL EXAMINATION

The heart and lungs are examined and general physical condition noted. Tuberculosis cases seen early in pregnancy as a rule should have an abortion induced; and if over seven months should have labor assisted as much as possible. The baby should not nurse. If a heart lesion is present, special attention must be given to avoid serious results. In some cases a cesarean section is the safest method of delivery.

The *blood pressure* is taken monthly for the first six months and then oftener as indicated. A blood pressure below normal often shows the need of a tonic; and while a high blood pressure does not always indicate toxemia, it acts as a danger signal. Especially is this true if the blood pressure after remaining normal for a few months suddenly rises. Chronic hypertension cases are bad risks and many authorities believe they should be aborted instead of attempting to carry them through their pregnancy with the risk of development of chronic nephritis and the knowledge that they will probably have a stillbirth.

The *urine* is examined monthly for six months and then twice monthly or weekly if indicated. Early in pregnancy, toxemia is shown by the presence of acetone and diacetic acid; while, later on, albumen and casts are usually found.

DIET AND EXERCISE

By weighing the patient each month we have a guide to the regulation of diet. The average patient should not gain more than 20 pounds during pregnancy, and the stout patient less. The gain should be gradual, since a sudden gain may precipitate toxemia. Excessive food not only tends to increase the size of the baby and to cause toxemia, but it fills up the pelvic canal with fat which retards the birth of the baby.

In regard to diet, starchy food should be eaten during the first three months. If there is much nausea, it should be taken every two hours. It is better to eat a little and often during this period. For the next three months, a general diet is allowed, care being taken not to over-eat. Sweets should be omitted and starchy food reduced. For the last three months, starchy food should be reduced still more (depending on weight), and sweets omitted. Meat should be reduced, and omitted during the last six weeks.

The weight cannot often be controlled by diet alone; the patient must exercise in the open air. At first (for three months), the patient should exercise very little as she is getting about with difficulty owing to the nausea and general malaise. There will be less nausea and less danger of a miscarriage if she does not exercise much during the first three months. After three months she should walk in the open air for one-half to one hour daily. This will not only help to keep down her own weight, but it will also have an influence on the baby's weight, and will improve the patient's metabolism more than anything she can do. This will reduce the incidence of toxemia and anemia. It also helps the head to settle into the pelvis before the baby gets too large. Occasionally the head is low in the pelvis and the patient's walking is limited for fear of a premature birth. It is therefore necessary to examine patients more frequently than formerly in order to prescribe the amount of exercise needed.

Automobiling and travel in general is not good for the average patient; although, if the patient is normal, there is generally no harm for her to drive a car to attend to errands about town. Patients with previous miscarriages should beware of automobiles.

TEETH

The teeth should be inspected by a dentist regularly. Fillings may be taken care of, but no serious work should be attempted. Extractions may cause a miscarriage, especially during the early months. An alkaline mouth wash should be used daily. It is not necessary for

most patients to take calcium and viosterol, although some may require it. Cramps in the legs are signs of a deficiency in calcium, and it should be given in these cases with viosterol. If a patient has the proper diet and exercise in the open air, preferably in the sunshine, her teeth are likely to remain in good condition with proper care.

BREASTS

The breasts may be gently massaged if painful and heavy, and during the eighth and ninth months the nipples should be bathed with a solution of borax in 50 per cent alcohol, followed by albolene. Some patients should wear a corset giving considerable support; while others should have no support for the lower abdomen, thus encouraging the child to settle into the pelvis. Systematic rest should be taken; as well as frequent bathing to keep the skin in good order.

HOSPITALIZATION

Patients should know what to have ready if intending to stay at home and also what to do if going to a hospital. Incidentally all primiparae should, if possible, go to a hospital.

A pelvic examination of the patient is of importance in determining:

1. Whether she is pregnant. Mistakes have often been made.
2. Duration of pregnancy, if dates are uncertain.
3. Presence of tumors.
4. Late in pregnancy, whether or not there are twins.
5. Whether or not the foetus is living.
6. The presentation and position of the child. If it is a breech, the question might arise whether to try to change it to a vertex. In breech cases, arrangements should be made for extra assistants at the time of delivery. Hospital care is advised.
7. The size and condition of head may be approximately made out.

PROGNOSIS

A prognosis of the case may be made and a fairly accurate idea obtained whether the labor will be slow and difficult or short and easy.

If a note of this is made, it is of great assistance when the call comes from the patient. It is very comforting to the patient to be told that everything is likely to be normal. When things are not normal, the less said the better until near the time for action. Sterile precautions should be used in making all vaginal examinations, special care being taken during the last month of pregnancy.

VAGINAL EXAMINATION

A speculum examination of the cervix should be made early in pregnancy to detect the presence of an erosion, a polypus, old laceration, or beginning cancer. If these conditions are diagnosed early in pregnancy, errors in treatment may be avoided later. The presence of a polypus, erosion, or cancer may cause a little bleeding which might easily be confused with a threatened miscarriage if one did not know of their presence. A *polypus* should not be snared off until after seven months, unless there is considerable bleeding, for fear of causing a miscarriage. *Erosions* are treated six or eight weeks after delivery with the electric cautery. When cancer of the cervix is present, cesarean section is the best method of delivery, afterward treating the cervix with radium whether the body of the uterus is removed or not. When the cervix is examined with a speculum six or eight weeks after delivery, it is of value to know what the condition was before delivery.

PUBLIC MEASURES

So much for the patient in private practice. How is this attention to be given to those who do not care, or who cannot afford to receive such attention? The most satisfactory method of carrying on prenatal care for the public is by having the work divided between a *clinic* and a *prenatal nurse* in the field who is paid by a medical society or some social agency. This method, modeled from the Maternity Centre of New York City, is well adapted for suburban or rural communities where there is not enough work for more than one or two clinics and where the distances prevent patients making regular visits to the clinic.

The nurse who is specially trained in prenatal work goes to the home of the patient, takes the blood pressure, makes a simple urinalysis, gives advice, and leaves printed instructions. Two or three times, or oftener if necessary, the patient is sent to the central clinic. If patients who are able to pay are seen by the nurse, she may charge a moderate fee and refer them to their physician instead of to the clinic.

At the clinic, the patient is examined by a physician to determine the presentation of the child and size of the pelvis. The heart and lungs are examined, the blood pressure is checked up, a complete urinalysis made, and a Wassermann taken. The patient has a card on which the nurse records her findings and which the patient takes to the clinic for the doctor to add his record. The card is taken to the hospital if the patient goes there for confinement; or if remaining at home she will have it there for the convenience of her physician.

GROUPS OF PATIENTS

There are four groups of patients.

Group 1. Those who intend to go to a hospital. They will be cared for and referred to any hospital they wish to enter.

Group 2. Those who have engaged a doctor or intend to have one but are having no prenatal care owing to the oversight of the doctor or the patient's inability to pay for it.

Group 3. Those who intend to have a midwife. These patients are watched carefully for complications, and if any arise the condition

is tactfully explained to the midwife and patient, and hospital care is advised. In case physicians or midwives have been engaged, their consent must be obtained before the patients are listed for treatment; and any abnormalities must be reported to them.

Group 4. Those who have not made any arrangement. These patients are advised regarding their cases, and are referred to a hospital or to a physician interested in obstetrics.

No patient who has a physician is given prenatal care without his consent. No patient who can afford a physician is referred to a hospital for confinement unless abnormal conditions are found, and then only after consultation with the physician or midwife in charge. By means of this simple scheme the obstetrician at the clinic and the prenatal nurse in the field work together as part of the same system, keeping in touch with the patient wherever she may live yet not interfering with her plans for confinement.

The more one studies prenatal work the more one is impressed with its importance. It should be preventive and not merely informative; that is, advice should be given in an effort to *prevent* complications, instead of detecting complications and treating them as they arise.

In my own experience, nothing has improved the results in obstetrical cases so much as more intensive prenatal care. If each county would seriously undertake to carry on better prenatal care in each community, it would do much to improve obstetrics and help to reduce maternal mortality.

THE SURGICAL ASPECTS OF PNEUMONIA

By RICHARD H. DIEFFENBACH, M.D., Newark, N. J.

Read before a General Session of the Medical Society of New Jersey at the Annual Meeting during a Symposium on Pneumonia, June 7, 1934

The surgical aspect of pneumonia resolves itself into the surgical treatment of the complications of pneumonia. There has been, of late, some agitation, I suppose one may employ that word, regarding the creation of an artificial pneumothorax in acute pneumonia. I have had no experience with this form of

treatment, and am not in a position to discuss it. My own deductions, however, lead me to believe that it is not a procedure to be used as a matter of routine.

The main complications of pneumonia in which surgical treatment is indicated are empyema, lung abscess, and suppurative pericar-

ditis. The last is rather rare and occurs only in the most severe and usually fatal cases. I shall, therefore, devote most of my time to the first two. One might include thrombo-phlebitis, as this condition has been favorably influenced by ligation, with or without removal of the clot. Since this is a more or less debatable method of treatment, I shall not include it in this summary. All are fundamentally complications due to pus formation, and in all some form of drainage is indicated.

There are a few essential points to be kept in mind. These are all complications of a severe primary disease and the patient is a poor surgical risk. Therefore, other things being equal, the surgical procedure selected should cause the minimum of shock. For this reason, local or block anesthesia is preferable. I, usually, preoperatively employ some barbiturate by mouth and, also, morphine hypodermatically to allay apprehension.

EMPHYEMA

Empyema is a common complication of pneumonia and is seen by everyone. It follows or accompanies both lobar and bronchial types. Its treatment depends on the time of its development in relation to the pneumonic process, and somewhat on the bacteria present. In other words, the treatment depends on whether the pneumonia has subsided by the time the empyema occurs, or whether the pneumonia is still active. The pneumonia is more likely to be still active if of the bronchopneumonic type, and if streptococci are present. We need really concern ourselves only with the presence or absence of an active pneumonic lesion as regards our choice of drainage; and this is, to my mind, the crux of the situation.

Many methods of empyema drainage have been advocated and described in the literature, but if we remember that the type of drainage to be employed is governed chiefly by the stage at which the pneumonic process has arrived when the empyema appears, the problem is simplified. Remembering the pathology, it is easy to appreciate that to create an open drainage, allowing air to enter the pleural cavity freely while there is still an active pneu-

monic process in either the same or the opposite lung, would still further embarrass respiration, cause sudden displacement of the mediastinal structures, and probably the death of the patient.

Empyemata may therefore be divided into parapneumonic, occurring *after* the pneumonia has subsided, and metapneumonic, occurring *while* the pneumonia is still active. In parapneumonic empyema, almost any type of drainage may be employed. Rib resection I find best, especially in adults. Intercostal drainage in children may be used and is often successful. One may wish to irrigate some of these cases, especially the closed drainage ones. One suggestion here—for the first few irrigations, use some non-irritating fluid, such as normal saline, because there may be a bronchial fistula present, and, if so, an irritating solution, such as Dakin's, will strangle the patient.

In metapneumonic empyema, we have a different problem, and some form of closed drainage, preventing sudden collapse and mediastinal flutter, must be considered. In children and even in adults, cases of empyema cured by repeated aspiration have been reported. Dr. Dana of New Orleans has found this method very satisfactory. He empties the entire cavity and replaces at least a part of the fluid with air. Others have advocated repeated aspiration and laid a special stress on preventing the entrance of air. It should be remembered that the sudden reëxpansion of a collapsed lung has been known to reactivate the underlying pulmonary process. I have had but few cases of empyema which cleared up completely with aspiration alone. In this connection it must be remembered that there are cases of pleural exudate accompanying pneumonia which are, strictly speaking, not empyema, and these have been known to absorb without removal of the fluid. I am not discrediting this form of treatment. I do not doubt that aspirating is successful in many cases if repeatedly and meticulously carried out.

My routine in metapneumonic empyema is, first, repeated aspiration. If the accumulation of pus is so rapid that it is difficult to keep it under control with aspiration, a closed underwater drainage is established. This may later

be supplemented with irrigation. Closed drainage is usually successful in children. If not, a rib resection may be done later. The latter I find necessary in adults as a rule.

Formerly, the drainage of an empyema was considered an emergency, and I well remember resecting ribs at all hours of the night and early morning. This conception of empyema has changed materially. There is only one type that may demand prompt action, that in which the fluid (usually thin, opaque, greenish, or serohemorrhagic) accumulates rapidly before the mediastinal structures are set by adhesions, and pushes the heart and great vessels to the opposite side. This causes cardiac embarrassment and respiratory difficulty, and this fluid must be removed early and repeatedly, though not completely, until such a time when a more permanent form of drainage is safe.

A few suggestions may not be amiss. As noted above, always use a local anaesthetic if possible.

For drainage material use the black, all-gum tubing. It is softer and less liable to erode the tissue.

In closed intercostal and other drainage be sure that the tube has a sufficient number of side openings. If this is neglected, the tube may extend above the fluid level, and drainage occur only when the fluid reaches the height of the tube. I have seen this cause a rise in temperature a number of times.

When possible, x-ray a chest before drainage. There may be more than one empyema cavity, or there may be an abscess in addition. In this connection, it is of interest to note that when two or more empyemata are present in the same individual, the bacteria of each one may differ from the others. *Pneumococcus* type "2" may be present in one, and *strep-tococcus hemolyticus* in another, etc. An x-ray is particularly indicated when the temperature does not fall to normal after drainage. Temperature usually means inadequate drainage, or a second empyematic accumulation.

The point at which to place the drainage tube is a question often discussed. There is no advantage in placing the tube too low. The diaphragm usually rises and interferes with

the drainage. I should say that the seventh or eighth rib or interspace is the most favorable site. This, of course, applies only to the larger accumulations. Smaller localized areas must be approached where they are located, and then I feel it is advisable to place the drainage as near the center of the accumulation as possible.

Complicated suction and negative pressure apparati are, in my opinion, not essential. There are two simple ways of closed drainage: by under-water drainage, and by tying a soft rubber finger cot with a slit at the tip over the end of the drainage tube. Both are simple and can be used anywhere.

Some empyemata are difficult of approach because they do not at any point reach the chest wall. The supradiaphragmatic, the interlobar, and the mesially placed belong to this group. They present individual problems, and may require a two-stage operation; the first to create pleural adhesions, and the second the actual drainage.

LUNG ABSCESS

In the discussion of the treatment of lung abscess, I shall, as I did in empyema, confine myself to the acute form.

An x-ray is essential in diagnosis, and may disclose the lesion before the typical clinical symptoms appear. I mention this because many chest surgeons advocate the external drainage of a lung abscess, peripherally placed, before it breaks into a bronchus, the contention being that the healing will be more rapid and the danger of spreading the infection to other parts of the lung lessened. Usually, however, the lung abscess will empty into a bronchus early and drain perorally. The post-pneumonic lung abscess is not always putrid. The pus has in some instance very little or no foul odor. I have no statistics, nor do I know of any, regarding the frequency of lung abscess as a complication of pneumonia. The abscesses are more likely to occur in broncho-pneumonia, and staphylococci have frequently been found, although some bacteriologists place the streptococcus first as an inciting agent.

The treatment is at first conservative with the possible exception of the type mentioned

above not rupturing into a bronchus. The ones communicating with a bronchus should have postural drainage first. If there is any improvement, as evidenced by physical signs, x-ray examination, lower temperature, gain in weight and strength, lessened amount and offensiveness of sputum, the treatment may be continued. Occasionally a patient is too ill and weak to attempt postural drainage immediately, and must be treated symptomatically until sufficiently strong to maintain an inverted posture.

It may be well at this point to mention salvarsan and neosalvarsan. Both have been advocated for the treatment of lung abscess. These would be applicable only in the putrid type containing spirilla. Arsenicals are damaging to liver cells and I should hesitate to give them in post-pneumonic cases, because as we all know, there is always a marked liver degeneration in pneumonia.

After having given postural drainage a fair trial and we find that the patient is not improving (and I wish to state that even a slight improvement is encouraging) bronchoscopic drainage should be carried out. With these two methods I feel that at least sixty per cent of the acute cases can be cured; but the treatment must be instituted early. The general practitioner can do a great deal by recognizing the lesion promptly and applying postural drainage immediately.

Failing to obtain the desired results with these two methods, we may consider *external* drainage. This can be done with a fair prospect of success, provided the abscess is not located at the hilum of the lung. Fortunately, the abscesses located at the root of the lung can be more readily treated with a bronchoscope; whereas the peripherally located abscesses, difficult to drain by the bronchoscope, are approachable by surgery. Post-pneumonic abscesses are, in my experience, more likely to be peripheral.

There are many methods of treating a pulmonary abscess surgically. Usually several ribs are resected over the area of involvement, and it is most essential to locate the abscess definitely. This can usually be done by x-rays, taken in various planes. It is always dan-

gerous to attempt localization by aspiration unless one is prepared to drain immediately because of the hazard of carrying the infection by the needle tract. The bacteria are frequently anaerobes and cause very serious and, at times, fatal cellulitis. For this same reason no part of the drainage wound of a lung abscess should be sutured.

After a suitable exposure, we must make certain that the pleural leaves are adherent. If the pleural space is free, some method for bringing about adhesions must be first instituted. This can be done by packing against the parietal pleura and waiting several days. Later the abscess is opened by cautery, incision, or high frequency cutting current. I find that packing the cavity with rubber dam, cut in strips, is an excellent method to maintain drainage. It is easy to remove, it exerts an even pressure, thus tending to control hemorrhage, and it does not block the drainage as does gauze.

Pneumothorax is another method of treatment for pulmonary abscess. It is not without danger, because during the collapse of the lung, the abscess may rupture into the pleural cavity. It is more suitable for an abscess located near the hilus of the lung. One may be forced to induce pneumothorax in an abscess which is doing well by postural or bronchoscopic drainage, in order to control a complicating hemorrhage. As a rule, pneumothorax cannot be successfully induced in post-pneumonic lung abscess because of pleural adhesions.

Phrenicectomy may be considered in an acute abscess; but it, along with other collapse operations, usually belongs to the treatment of chronic abscesses and will be omitted here.

SUPPURATIVE PERICARDITIS

Just a few words about suppurative pericarditis. Without surgery the mortality is one hundred per cent, while with surgery, it is about sixty per cent. The difficulty lies not so much with the treatment as with the failure to recognize the complication. Pericarditis is probably overlooked, or not thought of, which amounts to the same thing, more often than any other complication. So let us be on

the lookout for it, and we may be rewarded by a cure occasionally. Naturally, the cases developing pericarditis are the most severe ones, and the prognosis is very serious.

The approach to the pericardium is made through a vertical incision near the left border of the sternum, beginning in the third and extending to the fifth interspace, and then turning outward for about three inches. The fifth cartilage is then carefully raised so as not to injure the underlying structure, and resected. The internal mammary is then ligated. Care must be exercised not to open the pleura but to push it aside. The pericardium is opened between clamps. The fluid is allowed to escape slowly, because any sudden change in pressure may cause a dilatation of the heart.

Drainage is best maintained by an eighteen French catheter inserted for several inches into the pericardium. Care must be exercised in allowing space around the drainage tube so that a heart tamponade is not created, especially if irrigation is used. The pericardium may be sutured to the skin, and the tube inserted only when irrigating.

GENERAL COMMENTS

In summing up, there are a few points I should like to stress. Dressings in chest surgery of any type should be done by the surgeon. I do not wish to discredit internes in any way, but they are not sufficiently informed regarding the dynamics of chest surgery, and

many times I have been able to relieve distressing symptoms by so simple a procedure as shifting a drainage tube. I would repeat the importance of local anaesthesia.

Once again call your attention to the very grave danger of performing an open drainage operation in an empyema which is still complicated by an acute pneumonitis.

I hold no special method of drainage as superior to another. The general rule of the simpler the better, holds true here, as elsewhere. In comparing the results of the various methods of drainage, one should also note the mortality of the uncomplicated pneumonias prevalent at the time, and a close relationship will be found between the two as has been shown by Heuer and Graham. In other words, if the general mortality is high, so will be that of the empyema, and vice versa.

In this short resume I have attempted to cover some of the more essential points in the treatment of these suppurative complications of pneumonia. I have tried to confine myself to such methods of treatment which, in my experience, yield good results. Chest surgery is still in a formative state and we shall probably change our methods and views as we progress. If there is one thought I should like to leave with you, it is this: these are all serious complications in a patient who has, or is just recovering from, a severe primary illness. Let us therefore proceed with care and circumspection, remembering to treat the patient as well as the complication.

THE EXAMINATION OF THE ESOPHAGUS FOR FOREIGN BODY

REPORT OF AN UNUSUAL CASE

By ERWIN REISSMAN, M.D., Newark, N. J.

Roentgenologist, Newark Memorial Hospital

Read before the Section on Radiology of the Annual Meeting of the Medical Society of New Jersey.
in Atlantic City on June 6, 1934

Numberless objects are accidentally swallowed and pass out normally. Many are caught in the esophagus and are normally extracted. Some resist extraction, with fatal results. The esophagus, being a more or less flexible tube, is very accommodating and, until over-abused

and insulted, gives little evidence of its existence. It is certainly remarkable to what extent an esophagus can be dilated. Given time and opportunity, its lumen will stretch to more than 8 to 10 times its usual size, as in benign cardiospasm; and will, if this is relieved, re-

turn to normal. Foreign bodies in the esophagus are usually caught in certain definite places, according to the kind and size of the object. The physiological narrowings of the esophagus are at the entrance, opposite the lower edge of the cricoid cartilage; at the aortic arch; at the crossing of the left bronchus; at the hiatus near the diaphragm; and at the cardiac opening. However, if an object is caught at any point on account of its great size, gradual dilatation by its own weight and volume will facilitate its passage into the stomach. Objects which have sharp edges or points, such as pins, bones, needles, glass, metal, etc., may be caught anywhere, remain there and, unless extracted, cause considerable laceration, edema and even perforate, causing mediastinal involvement.

The examination of the esophagus for foreign body would appear to be a rather simple matter, with the proper means at hand, such as fluoroscopy and radiography. It would seem that nothing could escape the eye—and yet so many of them are missed. The reason, therefore, is largely one of improper technic, incorrect procedure or invisibility of the object. Most foreign bodies, especially metallic ones, are obviously recognized but others of the less or non opaque variety, such as vegetable matter, meat, fine meat bones, fish bones, chicken bones, buttons and especially those of a texture akin to the surrounding tissues are very elusive. Modern radiographic technic, with rapid exposure of the soft tissue technic, is of course very helpful in differentiating tissue densities, but in my hands the fluoroscope has given the best evidence. Radiography has subsequently confirmed the fluoroscopic findings.

There is nothing very startling or new about the method of examining the esophagus. The method which I use is probably practiced by every experienced roentgenologist, but the *invariable routine* of examination is the thing to be emphasized.

In the case of suspected foreign body in the esophagus the first thing to do is to get, if possible, a history of the cause; the method of onset; the nature of the foreign body; the symptoms which followed introduction; and the symptoms existing at the time of the ex-

amination. It must be borne in mind that the mere passage of an unusual object through the esophagus simulates its presence even after it has passed into the stomach and naturally the often repeated attempts to swallow aggravate the symptoms and cause nervous spasm. Also in cases where a sharp object has scratched the mucus membrane, the patient will often *believe* that it is still there and will even point to the place of irritation. *No manual examination* should be made.

The routine examination is carried out as follows: The clothes are removed and a flat film is made immediately. The patient is then examined under the fluoroscope. If the foreign body is seen and located, films are made in the right and left lateral and the antero-posterior positions. This gives the direction, position and location. Oblique exposures are generally misleading but often helpful and necessary.

If the foreign body is a bone too small to be seen by fluoroscopy or if it is of a non-metallic character or of a non-opaque character, the large gelatine capsule, filled with barium, is administered to see whether there is obstruction or even delayed descent due to spasm. If either exists, the capsule stops *above* the site of the foreign body. This examination is followed by a radiographic procedure with and without a fresh capsule in precisely the same positions as in fluoroscopy.

You will find that after the fluoroscopy is concluded the subsequent film, taken some minutes after, will still show the first capsule in situ. If it does not, give another capsule and make the exposure after swallowing. The inference can usually be decided by the absence of presence of the capsule. It is my experience that a *non-delayed* descent of a large No. 1 capsule means no foreign body. There may be some exceptions to this of course. There are quite a few gastric conditions which cause certain reflex spasms in the esophagus, especially at a point near the cardia, which simulates the presence of a foreign body in the esophagus. Also reversely there are some in the esophagus located near the middle third or lower which simulate distress due to a gastric lesion. Thus, by routinely examining the esophagus during

every fluoroscopy of a stomach case, many embarrassing difficulties can be avoided.

The principal object of this unimportant paper is really to describe a case in which this situation arose and the cost of such an omission was probably the life of the patient.

A. B., male, a Pole, 38 years old, weighing 187 lbs., strong, robust and healthy, who, when, under the influence of conviviality, dispensed with the usual and accepted method of opening beer bottles and used his teeth instead. A week before coming to my office he had a house party where he frequently indulged in this circus stunt. Following one of these attempts the cap seemed to disappear and, although they could not find it, the thought that he might have swallowed it never occurred to him or anyone else present. The next day during more sober moments he felt some epigastric pains but, as he said, no difficulty in swallowing. He consulted a physician who, in the course of a few days, sent him to a gastro-enterologist (who incidentally was also a roentgenologist) for a stomach examination. The report of the x-ray examination was negative. Naturally this did not help the patient,

so he consulted his family physician, who suspected an esophageal lesion and referred him to me for an x-ray examination of the esophagus. The man came to my office eight days after the incident with the beer-bottle cap and complained of epigastric distress but very little difficulty in deglutition. Fluoroscopic examination revealed the cap of a bottle with corrugated edges in the mid line of the thorax and in the middle third of the esophagus. The man entered the hospital the next day for esophagoscopy. This was done without the usual success. Two further attempts at different intervals were also ineffective. The edema of the mucus membrane, the exudate and the infestation of the metallic edges into the soft tissue made extraction impossible—at least so it was reported. After the last attempt, the esophageal wall was perforated, mediastinitis developed, with consequent tissue emphysema, and the man died.

It is not outside the realm of possibility to suppose that if the foreign body had been discovered earlier and before the irritation and inflammation had developed to the extent it did, the extraction by experienced hands would not have been so very difficult.

LATE OCCURRENCE OF STITCH ABSCESS: REPORT OF CASE

By CHARLES HYMAN, M.D., Atlantic City, N. J.

The incidence of stitch abscess is of fairly frequent occurrence shortly after the various surgical operations, but it is seldom seen as late as two years after a laparotomy. This case merits reporting because of the delayed appearance of this minor complication.

Case Report: B. R., age 37, male. Operated June 22, 1929, for ruptured gangrenous appendicitis. The appendix was removed and the abdomen closed with deep sutures of catgut. One cigarette drain was inserted and skin apposition was made with black silk and silk-worm gut retention sutures. The immediate post-operative course was normal. The drain was removed on the seventh day and the sutures on the ninth day. He left the hospital after twelve days completely recovered.

In August, 1931, the patient appeared complaining of soreness in the region of the appendiceal scar. This discomfort had been present and of increasing severity over a period of two weeks. The patient thought it due to some unusually hard work which he was doing at that time. Examination showed an inflamed, indurated and tender area at the upper pole of the old scar in direct relationship to the site of a retention suture. The application

of 25 per cent ichthyol ointment was advised for two days. After that time the area was considerably softer with definite fluctuation. An incision was made and a teaspoon of foul smelling pus suggestive of colon bacillus infection was procured. A probe inserted into the sinus reached a depth of about three-fourths of an inch. An indioform drain was inserted. The wound drained for about six days and healed without difficulty. The dressings were carefully watched for foreign material but nothing of any suspicious nature was found. The patient has remained free of trouble of this nature for the past two years.

I can find no satisfactory explanation for the appearance of this abscess at such a late date. One must assume, of course, that there was retained in the tract made by the suture needle a small portion of foreign material, most likely a flake which could have come from the silk-worm suture. A casual search of the literature does not reveal a similar case. Conversation with several surgeons of considerable experience does not reveal a like occurrence in their practice.

THE CLINICAL APPLICATION OF THE RECENT CONTRIBUTIONS IN FEMALE ENDOCRINOLOGY

By FLOYD E. KEENE, M.D., and FRANKLIN L. PAYNE, M.D., Philadelphia, Pa.

Read before the Medical Section of the Rutgers Club, New Brunswick, February 28, 1934

SUMMARY

The female sex hormones are described; and their application in tests for pregnancy is discussed.

The endocrines in various menstrual abnormalities and in sterility are described; and directions for treatment are given.

THE ANTERIOR PITUITARY HORMONE

Of the numerous hormones secreted by the anterior pituitary lobe, the one which stimulates ovarian function is of particular importance to the subject under discussion. This secretion, known as *prolan*, the anterior pituitary, the hypophyseal, or the ovary stimulating hormone, is constantly present in the female blood and urine in concentration too low for practical demonstration. A tremendous elaboration of a similar or an identical substance accompanies the onset of pregnancy. Whether it is then manufactured by the foetal tissues or by the anterior pituitary lobe is uncertain. Therefore, the term "anterior pituitary-like" is applied to this secretion which is eliminated in enormous quantities in the urine of pregnant women. There are approximately 1000 mouse units per litre at the end of the first month, with a gradual increase to 6000 units at the sixth month. Following this, a decrease occurs to 1000 units at term, with disappearance six to eight days after delivery. Pregnancy urine is the source of the "anterior pituitary-like" hormones, which are now marketed under the names of Antuitrin "S", Follutein, Prolan, etc. The uses of these products will be discussed after we have reviewed the sources of the ovarian hormones.

OVARIAN HORMONES

In response to anterior pituitary stimulation, the ovaries secrete two substances, the *follicular* and the *luteal* hormones. The follicular secretion (*estrin*) is constantly present in the normal female blood, reaching its highest concentration just before the menstrual period, when forty cubic centimeters of blood contain sufficient to induce oestrus in a castrated fe-

male mouse (one mouse unit). It is secreted in the urine at all times in amounts varying from 10 to 100 mouse units per litre. During pregnancy it is also manufactured by the placenta, the amnion, and the corpus luteum, when enormous quantities are secreted into the blood and eliminated in the urine. The chief sources of the commercial supply are the urines of pregnant women and mares, and the amniotic fluid of cattle. It is marketed under numerous trade names, as "Theelin", "Amniotin", "Estrogen", and "Progynon".

The second ovarian hormone is derived from the corpus luteum. Among the numerous functions ascribed to it may be mentioned: inhibition of follicular development, preparation and sensitization of the pro gravid endometrium for nidation of the fertilized ovum, and protection of the embryo during the early weeks of its existence. The luteal hormone has never been isolated from the human blood or urine. Because of difficulty in extraction and instability of the product, the corpus luteum extracts which are now available for clinical use contain little or no active material; and whatever effect they have must be ascribed to small amounts of estrin. Knowledge of these facts is of extreme importance in modern diagnosis and treatment of many obstetric and gynecologic conditions, as will be shown in the subsequent discussion.

PREGNANCY TESTS

Ascheim and Zondek in 1928 demonstrated that following repeated small injections of pregnancy urine into infantile mice, there occurred a marked ovarian stimulation with development of hemorrhagic follicles and corpora lutea. This formed the basis of the first

specific test for pregnancy. In 1930, Friedman and Lapham proposed the use of mature, non-pregnant, female rabbits in which a similar reaction was obtained. The Friedman test is now recognized as being 98 per cent accurate. Other points in its favor are the lack of technical difficulties and the rapidity of the reaction which occurs 24 to 48 hours following the initial injection. Occasional false positive reactions are said to occur in the presence of the menopause, primary ovarian amenorrhea, pelvic malignancy and hyperthyroidism. Based upon the experience of over 300 Friedman tests, we believe that the false positive is less likely with the Friedman than with the original Ascheim-Zondek in which mice are used. Several practical points concerning this test deserve mention. A concentrated morning specimen of three ounces should be submitted. Sufficient concentration is obtained by instructing the patient to withhold fluids the preceding night. The use of coal tar derivatives by the patient will render the urine extremely toxic when injected. Urine collected within forty-eight hours after a prolonged anesthesia usually kills the animal. The specimen should be kept cool until it is submitted. If this is impossible one cc. of Toluene should be placed in the specimen bottle. For clinical purposes, it is wise to wait until the patient is ten to fourteen days overdue. At this time a negative reaction is absolutely dependable, provided the technic of collection, injection, and interpretation have been properly conducted.

Because of the abundance of female sex hormone in pregnancy urine, Mazer and Hoffman have suggested the estrin test for pregnancy in which castrated female mice are used. When abortion is threatened, the estrin test is of distinct value, for foetal death can often be diagnosed by a marked decrease in the estrin content of the blood and urine. We prefer the estimation of the estrin in 40 cc. of blood, as advised by Frank. With a negative test for estrin, despite a positive Friedman test for prolán, abortion is considered inevitable.

Hydatidiform mole and chorion epithelioma may be readily diagnosed by the hormone tests. In both conditions, the urinary elimination of anterior pituitary-like hormone shows an enor-

mous increase over that found in normal pregnancy. The test is of necessity a *quantitative one*. Murphy has shown that in normal pregnancy the prolán elimination for twenty-four hours remains constant regardless of the quantity of urine secreted during that time. Therefore, for quantitative determination of prolán excretion, a twenty-four-hour specimen of urines is essential, and the findings should be expressed in terms of animal units per twenty-four-hour specimen. Recently, a patient with suspected hydatidiform mole was found to eliminate more than 150,000 rabbit units of prolán in a 610 cc. twenty-four-hour specimen of urine. The fact that this is over ten times the normal elimination for that time of pregnancy made the diagnosis of mole obvious. After expulsion or removal of the mole, a rapid decrease in prolán occurs although the urine may contain demonstrable amounts for sixty days. Persistence longer than sixty days, or a quantitative increase during that time, strongly suggests the development of chorion epithelioma. It is, therefore, wise to follow all cases of hydatidiform mole by periodic quantitative examinations of the urine for prolán for at least six months after operation.

Following delivery or abortion, the anterior pituitary hormone usually disappears from the urine within two weeks. Unexplained post-abortion or post-partial bleeding should arouse suspicion of chorion epithelioma. Repeated quantitative determinations of the prolán content of the urine can be depended upon to confirm or refute this suspicion.

Subsequent to operation for chorion epithelioma, this hormone should promptly disappear from the urine. Persistent positive reactions obtained from decreasing quantities of urine, taken from twenty-four-hour specimens, indicate local recurrence or distant metastasis, thereby offering a most valuable guide in prognosis and treatment.

ENDOCRINES IN AMENORRHEA

The studies indicated in amenorrhea include quantitative examination of the blood and urine for female sex hormone over a period of four to five weeks. This study demonstrates one of three conditions: First, *subnormal*

amounts of female sex hormone in the blood and urine; second, no demonstrable female sex hormone in the blood and very little in the urine; and third, a negative blood cycle with normal or excessive urinary elimination. Our experience indicates that the first two types—due to deficient manufacture—are far more common than the last. Estimation of the prolactin content of the blood and urine is also of value. Fluhmann and others have shown that following castration, an easily demonstrable increase in the anterior pituitary hormone of the blood occurs. A similar excess is commonly found in the normal menopause and in a small percentage of functional amenorrheas. In the event of such a reaction, the failure to menstruate is considered primarily of ovarian origin and the prognosis is less favorable than in the type which follows pituitary deficiency.

Since the thyroid gland is closely related to the female sex organs, the basal metabolic rate should be routinely determined, and a careful search made for physical stigmata of dysfunction.

TREATMENT OF AMENORRHEA

Both the hormone investigation and therapy of amenorrhea are still in their infancy and the results are often disappointing. Thyroid extract stimulates metabolism and its cautious administration is indicated even when the basal rate is not particularly low. The dose should be gradually increased until the patient's point of tolerance is reached, as indicated by either nervous symptoms, a sense of fullness in the throat, dyspnoea, or tachycardia, and then continued slightly below this level. This agent is most useful in oligomenorrhea (scanty periods with irregular, prolonged intervals) or amenorrhea associated with obesity.

Estrin is advised unless the excretion of this hormone has been found to be normal or excessive. It does not stimulate ovarian activity; on the contrary, experimental evidence indicates that large doses may have the opposite effect. It does seem to increase the growth and vascularity of the uterus, with proliferation of the endometrium, thereby rendering these structures more adaptable to the menstrual function. While adequate treatment with estrin occasionally results in periodic uterine bleed-

ing, it is not true menstruation, since the premenstrual endometrial change, which depends upon the luteal hormone, is not induced.

The administration of the anterior pituitary hormone in the treatment of amenorrhea has been disappointing. It has not been demonstrated that the human ovary reacts to the usual doses of this substance. In fact, after huge doses of prolactin several investigators have failed to find normal stimulation of follicular or luteal development in the ovaries of patients who were subsequently operated upon.

We do not know whether x-ray in small doses stimulates or inhibits glandular function. However, the results of the so-called stimulating doses of x-rays to the ovarian and pituitary areas justify their use in the treatment of amenorrhea except in primary ovarian failure with hyperfunction of the hypophysis, when pituitary irradiation is contraindicated. X-ray treatment is not advised in oligomenorrhea because of the danger of permanent amenorrhea nor should it be used for patients who are eliminating normal quantities of estrin. Our experience has been that the patients with primary amenorrhea—that is those who have never menstruated—do not respond to treatment. Under such circumstances, the glandular dysfunction has probably existed since early childhood, as evidenced by the faulty development of the pelvic organs. With secondary amenorrhea, the outlook is more hopeful—since one-third of those with no period for six months or more respond to treatment and two-thirds of those with irregular, prolonged intervals and scanty flow are benefited.

DYSMENORRHEA

The treatment of primary dysmenorrhea is difficult, because of the lack of knowledge concerning its causes. The usual pelvic findings which are associated with this symptom, uterine hypoplasia, anteversion, or small follicular cysts of the ovaries, are but local manifestations of abnormal endocrine function. Study of the female sex hormone content of the blood and urine is of little value, except on rare occasions when a deficiency of estrin is found. Theoretically, these patients should respond to the administration of female sex hormone, but our experience indicates that less than 50 per

cent of them do so. In case estrin therapy is contemplated, doses far in excess of that advised by the commercial houses should be administered. Thyroid extract should also be prescribed in gradually increased doses until the patient's point of tolerance is reached. Based upon the belief that the anterior pituitary-like hormone acts as an inhibitor to uterine contractions, Novak has suggested its use in the treatment of dysmenorrhea. Our experience with it has been limited and our results disappointing. We believe that dysmenorrhea, in the majority of instances, is not amenable to any form of endocrine therapy now available.

MENOPAUSAL SYMPTOMS

The hormonal treatment of menopausal symptoms has occasioned much contradiction and reports vary from complete success to absolute failure. The menopause is a polyglandular syndrome with diminution or cessation of certain glandular activities, accompanied by increased function of other endocrine organs. Therefore, the occasional injection of a single hormone should not be expected to control these symptoms. Of the two products now available, the anterior pituitary-like hormone is definitely contraindicated in treating menopausal symptoms, because the patient already has an excess of this substance in her blood and urine. Estrin does seem to give relief occasionally, but it is questionable how much is due to the hormone and how much to psychic reaction. As Zuzrok pointed out, before estrin is administered the patient's urine should be studied for female sex hormone. Many women presenting severe menopausal symptoms continue to eliminate small quantities of estrin, in which case it is useless to give more. If estrin is indicated, the oral administration is advised, because of the continuous absorption in contrast to the periodic introduction necessary to hypodermic therapy. Here, as in other conditions to be treated by estrin therapy, the dosage should be most generous.

FUNCTIONAL STERILITY

The problems in sterility which enter this discussion are those of female infertility which are functional in origin. The menstrual habit is a fairly accurate index of endocrine activity.

Derangements in this habit, such as oligomenorrhea, amenorrhea, or irregular bleeding are often associated with sterility or the tendency to abortion. However, functional sterility is not uncommon in women whose menstrual habits appear to be normal. Hartman has shown that menstruation without ovulation occurs in the monkey, and evidence warrants the conclusion that the same may occur in the functionally sterile women who seem to menstruate regularly. Estimation of the estrin blood and urine content taken two to six days prior to the menstrual onset is of value in diagnosing what may be termed pseudo or an-ovular menstruation. The finding of subnormal hormone content of the blood and urine at this time is indicative of deficient ovarian activity. A more valuable test is examination of the endometrium obtained a short time prior to the expected period. In women who menstruate regularly, a simple premenstrual curettage can be arranged easily; but in case of menstrual irregularity, specimens of endometrium should be taken at weekly intervals until four or five are obtained or until bleeding occurs. This is readily and painlessly accomplished by use of the Burch endometrial suction cannula. The absence of the characteristic premenstrual picture is positive evidence of corpus luteum deficiency, under which circumstances even though pregnancy should occur, early abortion would in all probability result.

The treatment of functional sterility is often disappointing. The measures indicated in amenorrhea or oligomenorrhea which are often associated with sterility have been discussed. In case the normal premenstrual phase is lacking, the efficacy of hormone therapy is questionable. Under such circumstances, the anterior pituitary hormone should be useful, but the uncertainty of dosage, species differences in ovarian response and the absence of proof that the human ovaries do respond throw doubt upon its value. The luteal extracts now available for clinical purposes are inert and useless. With subnormal sex hormone in the blood and urine, as demonstrated by the studies which Frank has suggested, the administration of estrin is indicated. Numerous reports have appeared in the literature showing favorable results following small doses of x-ray to the pituitary and

ovaries. This probably is of more value if it is preceded by the administration of estrin because of its supposed sensitizing effect upon the uterus and endometrium.

FUNCTIONAL UTERINE HEMORRHAGE

Abnormal uterine bleeding in the absence of demonstrable pelvic pathology, blood dyscrasia, or constitutional disease is now considered to be of functional origin. For years this bleeding was ascribed to certain conditions within the uterus, as for example chronic endometritis, fibrosis uteri, arterio sclerosis, etc. Later, the endometrial changes and irregular bleeding were thought to result from abnormal development of the Graffian follicles and absence of the corpora lutea. Since the anterior pituitary gland has been recognized as the motor of the ovary, functional bleeding is believed to result from either abnormal pituitary stimulation or defective ovarian or endometrial response to this hormone. Thus we have the possibility of several functional derangements, each of which is capable of producing these menstrual abnormalities.

Functional bleeding often occurs without characteristic ovarian or endometrial changes. In the majority of instances, the endometrium presents no typical alterations, the microscopic picture being that of the normal interval stage, or even moderate atrophy. The absence of proliferative changes indicates that some factor other than excessive follicular stimulation must cause the bleeding. It has been suggested that this influence may come from the pituitary gland and act directly upon the endometrium.

In another type of pituitary-ovarian dysfunction, the cycle is repeated too rapidly so that the endometrium passes through the proliferative and secretory phases with the occurrence of menstruation in an abnormally short time, often as frequently as every two weeks.

In the third group, which consists of about one-fourth of the cases, hyperplasia of the endometrium is found. This is most likely ascribable to some alteration in the anterior pituitary secretion, to which the ovaries respond by excessive or prolonged follicular development and diminished or absent luteal activity. A marked proliferation of the endometrium results, characterized by overgrowth

of the stroma or the development of greatly hypertrophied, irregularly shaped endometrial glands which give the appearance of Swiss cheese upon microscopic examination. From this enumeration of the many types of endometrium which occur in functional bleeding, it is obviously not a clinical entity, but a symptom arising from any one of several types of endocrine dysfunction.

COMMERCIAL EXTRACTS

The use of glandular extracts, as Corpus luteum, whole ovarian gland and the widely advertised shot-gun remedies, in the treatment of functional hemorrhage has been of no value. Two endocrine products have been introduced which are often effective, thyroid extract and the anterior pituitary-like substance. Many adolescent hemorrhages respond to thyroid medication alone even when definite evidence of thyroid deficiency is absent. The anterior pituitary hormone finds its greatest usefulness in the treatment of functional bleeding in young women. Experimentally, the mechanism of its action is luteinization of the ovarian follicle. As previously stated, such action has not been demonstrated in the human and leading endocrinologists do not accept this hypothesis, but prefer to look upon its effects as purely substitutional. Novak believes it is inconceivable that luteinization could occur with the rapidity that bleeding ceases in some cases. He considers the action to be upon some obscure bleeding factor, probably of anterior pituitary origin.

The anterior pituitary sex hormone is usually administered as a concentrated extract, many types of which are now on the market. It is effective only when given hypodermically. During active bleeding, the dose should be 200 rat units daily, for six to ten doses, to be stopped when the bleeding ceases. During the interval between periods, 100 rat units every third day are advised. With recurrence of bleeding, the larger dose is resumed and continued until the bleeding ceases, when no further treatment is given until the character of the next period is observed.

The results of this treatment are promising but not uniformly good. Young patients respond much more often than do those in mid-

dle age. It is considered by some to be entirely effective for adolescent hemorrhage but our experience does not confirm this belief. In our hands, two-thirds of the patients less than thirty years of age, and one-third of those from thirty to forty have been temporarily restored to normal. In a considerable number of patients above forty, it has been a 100 per cent failure. The etiology of bleeding in the menopausal decade is unlike that in the other age groups. Here, an initial ovarian depression with subsequent hyperfunction of the anterior pituitary lobe occurs. To add more of this hormone is theoretically unsound and clinically useless. Furthermore, the possibility of a myoma or fundal carcinoma as the cause of the abnormal bleeding at this age is too great to waste time on useless hormonal therapy. The permanency of the results of glandular therapy is still in doubt. Sufficient time has not elapsed to permit us to state the percentage of permanent cures, yet we are impressed with

the number of young women who have temporarily responded. Even if the results are not permanent, temporary control of the bleeding justifies the treatment, which is not harmful and may be repeated if necessary.

CONCLUSIONS

The recent advances in female endocrinology are of greatest value in the diagnosis of pregnancy and its complications; hydatidiform mole and chorin epithelioma. In the study of amenorrhea and functional sterility, the hormone tests aid in determining the type of glandular aberration which prevails.

In the treatment of functional disorders, hormone therapy has definite limitations. It is occasionally effective in amenorrhea, dysmenorrhea, and the menopause; but is rarely, if ever so, in functional sterility. The most satisfactory results are seen in the treatment of functional uterine hemorrhage but here it is by no means universally curative.

THE PHYSICIAN AND PRINCIPLES OF ORGANIZED MEDICINE

By EDWARD W. SPRAGUE, M.D., Newark, N. J.

The President's Address at the 119th Annual Meeting of the Essex County Medical Society in Newark, October 11, 1934

Tonight marks the passing of the one hundred and nineteenth year of the Essex County Medical Society. Such an old and honorable society has had many opportunities to be of service to the physician and the public. Probably at no time has this Society, or in fact the entire medical profession, faced a more serious and perplexing general condition of affairs. The past few years have witnessed a great economic upheaval. We are in a state of disillusionment. Old, long settled nations are now unsettled. Grief and suffering are prevalent. Security changes to insecurity. Contracts are held lightly. Constitutional rights are being encroached upon and certain rightful liberties are limited. At this time there is a wide and persistent interference with economic laws which may have a prolonging effect on the depression. Witnessing the existing cruelty and general wretchedness among people, we cannot escape the conclusion that we live in a dangerous world today, that the

evolution of man is neither complete nor perfect as yet.

However, there are powerful forces of enlightenment still at work in the world and, fortunately, the profession has had the remarkable moral guidance of the ideals and ethics laid down centuries ago by Hippocrates, and maintained since by equally great physicians. Such a heritage has many times prevented the drift to lower levels of conduct and thought and we have all felt its moulding influence on character. It has strengthened our faith and hope in the undying self-regeneration of the spirit of mankind, and belief in the upward, though uneven evolution of civilization to ever higher levels. The physician believes in the surviving force of moral principles.

PROFESSIONAL ADJUSTMENTS

The physician, in the midst of this economic and political maelstrom, cannot entirely escape the pressure and distorted perspective all this

engenders. Economic collapse threatens individuals as well as governments; and as a result, frantic efforts are being made to change the old order. Experimentation is the vogue, and many false legislative steps may be taken. Surely the impact of this blow will change some of our social and economic ideas and some of our institutions either for better or worse. Certain efforts may even reach to our established methods of practice, as has been done in several foreign countries. Such plans might effectively limit the individual physician in his private practice of medicine.

Therefore, we, as trained men, must heed this challenge which has been thrown to us in the open theatre of world changes and events. We must face the issue squarely and fearlessly and do our utmost to preserve for every one the principles of liberty, of freedom, and of democracy. Here and now let us save the precious and vital principle of self-government in our profession.

To preserve these tenets, we must base our convictions and actions upon principles which result from experience, examination, and sound reasoning; not upon a selfish interest or a favorable chance.

To that end, at the beginning of this year in Essex County, a review of the various economic questions which were disturbing the profession was made; the problems were allotted to committee groups which were assembled to consider the subjects. The committees have sought what is best for the patient and a more secure economic situation for the physician, and have attacked each problem presented. Some of our aims have been accomplished and some may not be fully accomplished for years to come.

SOCIETY PROGRESS

The live interest of the members this year has been phenomenal. There is a fine spirit of solidarity. You have emphatically encouraged and upheld the acts of the administration; and whatever has been accomplished, or is in process of doing, whatever principles we have established and whatever vision has been displayed, is the crystalized result of your col-

lective opinion. This is your society and it has been a stimulating experience to have been elevated to this high office of presidency.

The deliberations and actions of your Council have been based upon loyalty to the Society and to the profession. The Council has worked for the patient's welfare. It has been an inspiration to serve with a group whose animating purpose has been on such a high, unselfish plane. The Council's philosophy is that the great mass of people must be adequately cared for or no plan of practice will stand. That viewpoint is thoroughly sound.

PRINCIPLES OF MEDICAL PRACTICE

The greatest result of the year's effort has been the gradual development and the understanding of the principles underlying good medical practice. These we are resolved to preserve. We believe the continuance of such well-tried procedures of practice will result in further advancing the best welfare of the patient and our belief in these principles is strengthened by the fact that wherever serious deliberation has taken place throughout the length and breadth of this land, identical crystallization of thought has resulted.

Let us restate these principles and lay them down as fundamental.

It is axiomatic that the individual patient has been and always will be the basic unit of medical practice.

1. We believe the trusteeship of individual and collective health belongs to the medical profession. The physicians fully sense the responsibility of this trusteeship. They unselfishly pool their knowledge of medicine and the results of their scientific discoveries and attainments for the common good.

2. We believe in medical leadership in medical problems. The training especially fits the physician for the work.

3. We believe in protecting the high quality of medical service.

4. We believe that *regimentation in any form* is ultimately destructive to the best interests of the patient.

5. We believe in the preservation of the principles of self-government in medical practice as manifested in the personal physician-

patient relationship and the free choice of physician. Compulsions contrary to human nature are particularly dangerous in medical matters.

6. We believe a third party in physician-patient relationship is detrimental to the best interest of the patient, and leads to the building up of political interference, which has no place in the field of medical treatment.

7. We believe whatever system is devised for the sharing of the burden of medical care of the poor by the State, should be developed with the coöperation of the official body of organized medicine, and should be under the direct supervision of physicians and be in harmony with the previously mentioned principles.

8. Lastly, we believe in the dignity and moral responsibility of our profession, and in its thoughtful purpose to serve best the public moral and physical health.

A mere statement of these principles will not alone maintain the profession in its proper position in society. The vision must be accomplished by action. Our altruism is admired by the individual patient and the world at large. Our scientific attainments increase in an almost unbelievable manner; our practical accomplishments are most impressive; and the possibilities of bringing relief to suffering humanity are ever widening and the physician occupies the enviable position of the only one able to use this knowledge fully. The public gives assent to all of this. But when it comes to the methods of practice, then we encounter the effects of the stress of general economic forces on the State, on the individual and on the physician. The physician is bound to be caught up in the web of this general attempt at change. At this point he meets suggested new forms of practice.

THE COUNTY MEDICAL SOCIETY

It is here that the individual physician must stand on the sound ground of the principles of practice. It is at this point he realizes the helpfulness of his County Society, in which we assemble ourselves with a common purpose and willingness to work, making service and high general purpose our motive. By coöpera-

tion we are enabled to present a strong directing influence toward the aims we wish to achieve. The County Society is a great device whereby we solve perplexing problems. In the county we can see the direct results of various practices. Here we sense the reactions of society as a class to our methods. Correct interpretations and guidance in our work naturally emanate from the experiences of this large deliberative body of competent men and women.

The work of the year has reached into many fields. Time does not permit proper mention of all of the activities and their accomplishments.

Several definite and practical steps have been taken; such as Cancer Week; the relationship of the Emergency Relief Administration; the incorporation of the Society; the setting up of a Relief Fund; and the organization of the Public Relations Group in which the Sections on Economics, Hospitals and Public Health have rendered monumental service. The Physician's Lien Law has been enacted and a Fee Schedule planned which is ready for the County Clerk; and the State Public Health Plan has been set in motion. All these will prove of increasing value as time goes on. Hopes and generalities are being translated gradually into realities.

PUBLIC HEALTH

Certain potential possibilities of several of our Commissions should be brought to your attention—Cancer Control, Maternal Welfare, and Heart Problems.

These groups present opportunities of great service to the public. They stress the leadership by the profession in medical matters. Eventually, all these public health contacts should be coördinated with our general Public Health Committee.

The physician is an indispensable factor in matters of preventive medicine and public health. It is a duty of organized medicine to quicken his sense of responsibility, to make the physician conscious of his influence, and to promote a closer and more enthusiastic co-operation between the profession and the estab-

lished health officers. This must appeal to every physician. He is interested in public welfare and is the greatest single factor in building up general health. The Detroit Plan suggests a workable way for the physician to reestablish his leadership. The advantages to the public of returning practice to the physician's office are obvious. Preschool examinations, inoculations, and periodic examinations are examples. We are making an excellent start on this plan. With our own approval ethical letter of solicitation for preventive inoculations, and with the round-up of field nurses and other agencies, the citizens should be better protected now at less public expense, and each physician will be a public health officer.

Our Public Health Committee has accomplished much in its brief existence and desires to serve the public. We offer information and coöperation to the public agencies. This plan extends beyond the service to the individual to the service of the community as a whole. We are guardians of the public's health and as such should urge definite study by the County and State Societies of the problems of preventive medicine and of chronic illness.

The enthusiasm and interest of all the other committees have been of vital importance. The committee chairmen and the members sense the seriousness and possibilities of their work. They have accomplished a great deal; much of this is in new fields of action, and I desire to express my sincere thanks to them.

At this point, let us not forget the kindly interest and practical helpfulness of the Women's Auxiliary of the Essex County Society. Its members are anxious and willing to be of service to the physicians and to the public; and this year contributed a comfortable sum to our Relief Fund. May the enthusiastic help of the Women's Auxiliary fire our will to build and maintain this benevolent fund which has been the bearer of comfort to some of our members this year.

As events take new turns, we must organize groups to study the trends. Our Society must prepare itself for whatever impacts social turmoil may launch against the established order of medical practice.

EMERGENCY RELIEF ADMINISTRATION

In 1926, in New Jersey, the Legislature added the fourth dimension in relief, namely, medical care.

Shifting the burden of medical service from private to public agencies has its dangers—even in an emergency. We must do our utmost to prevent pauperization of the people.

For ages we have quietly given adequate medical care to those in need. In this period of unprecedented depression the government is giving material assistance to the physician that he may better carry the burden he now bears.

Our Medical Advisory Committee has developed a broad philosophy and practical management of this problem. The committee reports with pleasurable satisfaction, on the general honesty of the physician.

This whole scheme must be economically managed or the expense will cause the Federal Government to develop other forms of care of the poor. Our present plan preserves the principles for which we stand. Utmost individual coöperation is essential. Emergency relief should be for the emergency only, and we should revert to established methods of practice when emergency measures are no longer necessary. Viewing conditions as they now are, the time of return may yet be far off. In this emergency, there is a call to sacrifice individual time, money and energy for the common good.

RELATED PROFESSIONS

This year two initial points of contact have been made with the related professions of dentistry and pharmacy along two lines:

1. Economic.
2. Educational.

The educational effort has been started by our Committee on Education and Post-Graduate Instruction; and the economic endeavor has been made through our Welfare Committee. It is my belief that conferences with the legal profession should be held to review the whole subject of medical testimony. The bringing together of professional groups should result in mutual benefit and appreciation of common purpose.

MEDICAL PRACTICE ACT

There is a lamentable need for many changes in the Medical Practice Act and its functions. Adequate prosecution of illegal practitioners has been slow.

At present, the State Medical Society has a committee in the field studying the essentials to be embodied in a uniform practice act. The matter is of such great importance, especially to Essex County, that I believe a special committee from the county should review the whole subject and present its findings to our Council. Whatever is approved by our Society should be sent with recommendations to the State Trustees for the consideration of the State Committee. A law or amendment is needed which will prohibit the practice of medicine by corporations. An amendment is needed which grants to the Medical Licensing Board the power to suspend licenses. That would give to the Board disciplinary control over all physicians, whether members of the County Society or not. Suspension should be based on a violation of ethics in either of two respects:

1. Any act against the *public welfare*;
2. Any act which is against the *ethics* of the medical profession as a whole.

This would cover advertising, medical offices, corporations, or physicians who lend their names to corporations or associations practicing medicine.

The standard of ethics should be that which is set up by the State Society.

STATE MEDICINE AND HEALTH INSURANCE

It is to be presumed that some form of public medical practice is an approaching possibility.

State medicine in its broadest sense relates to the medical care of all levels of society.

Health insurance relates to care of a selected group whose incomes are below the comfort level.

State medicine in many forms exists here at the present time. Over fifty per cent of the ill population is now cared for in public institutions by the State.

Health insurance exists in an experimental

way in a few localities already but as yet is not well established anywhere to include persons in the lower income levels.

The California State Legislature recently appointed a Senate Committee to study the question and to report in January with a draft of a health insurance bill if it found need for one.

The Michigan State Medical Society memorialized the House of Delegates at the last session of the A. M. A. The opening paragraph reads:

"There is substantial evidence that powerful forces and agencies are working toward the development of health insurance."

On August 31st, 1934, the Honorable Frances Perkins, Secretary of Labor, delivered an address over the radio in which she said:

" * * * the President, in his last message to the Congress in June, suggested adding protection to the individual against many hazards which are likely to involve him in distress and dependency. He followed this suggestion by creating a Committee of his Cabinet and other officials, on Economic Security, of which I have the honor of being named Chairman; whose other members are the Secretary of the Treasury, the Attorney General, the Secretary of Agriculture, and the Federal Emergency Relief Administrator."

Mr. Harry L. Hopkins, the Federal Emergency Relief Administrator, is a member of this committee. In an article in the New York Times, Sunday, August 19th, 1934, Mr. Hopkins refers directly to "Health Insurance with Medical Care".

On August 23rd, 1934, I wrote the following letter to Mr. Hopkins:

"In the New York Times, Sunday, August 19th, 1934, in your article 'Beyond Relief: The Larger Task' you refer to 'Health Insurance with medical care' and 'so this becomes a logical objective for any commission charged with public welfare'.

"I am the President of the Essex County Medical Society of New Jersey, with nearly 1,000 members. Would you please let me know if your Department, or any other Department, has plans on foot to institute health insurance. If so, could you briefly outline your plan, or refer me to the proper department where I may secure information. Below what income level are you planning insurance; is it to be financed by government, or insurance companies; have you conferred with the officers of the American Medical Association in the matter; will the management of the plan be under physicians

or lay control? This whole question is a vital one to all concerned.

"There have been many rumors of health insurance, and some allusions to it and much guessing about it. Would you please give me first-hand information on the subject.

"Awaiting your reply * * *"

On August 25th, 1934, I received the following reply:

"Mr. Harry L. Hopkins, Federal Emergency Relief Administrator and a member of this committee, has asked me to acknowledge your letter of August 23rd and to give you information of your question as to whether health insurance is contemplated by any Federal department.

"In answer to this question, allow us to say that the President created the Committee on Economic Security to make recommendations to him on a program which will give economic security to the individual. We have only recently begun our studies, and do not expect to make our report to the President until December 1. Health Insurance will receive some consideration in this connection, but the major consideration, at this time at least, is being given to unemployment and old age retirement.

"For your further information about this committee and the purposes of its studies, we are enclosing a copy of a radio address delivered by the Secretary of Labor, who is the Chairman of this committee, some time ago.

"If this does not give you all the information desired, we shall be glad to have you write us again."

"Sincerely yours,
Committee on Economic Security,
EDWIN E. WITTE, *Executive Director.*"

Now you can see plainly that the problem of Health Insurance is being considered by the National Government. While it may be very indefinite as yet or not in form for Congress, it is of potential concern to us.

Any new scheme of practice must square up to the recently laid down ten rules approved by the last House of Delegates of the American Medical Association, and it must satisfy our fundamental principles of practice whereby we believe the patient receives the best professional care. We must oppose a system which is utterly impersonal.

By united action we can prevent the establishment of practices harmful to the public interest. Your inactivity, or indifference, or self-delusionment may defeat our purpose—nothing else will. Through our State Society, we must urge the A. M. A. to contact the Government while this whole problem is in a plastic state, and to present our viewpoint. Let us exert

ourselves to direct great social problems concerning public health along the lines we believe to be right for Society.

All health insurance schemes need our well-focused thought. Let us not mark time now while regimentation marches down upon us or while our opportunity to save our principles marches away from us. We must recover where we fumble. We must show new strength where we appear feeble. Those who have eyes to see which are not blinded by smug complacency, and ears to hear, which are not deafened by indifference, must recognize these unpleasant conditions and see the encroaching danger. When the day comes we must be ready.

Threatened danger firmly cements any group. Therefore, our great hope is in *organization* and in an aroused, carefully thoughtout course of action. We must gain our rightful recognition as a powerful force, whose understanding and whose desire to be helpful will eventually be sought after by the government in its attempt to solve the problem of medical care for the poor. This whole problem should be guided by and under the control of the medical profession. This is the crux of our position.

Various forces are at work to capture the present-day mass-mood of society. Society is anxious for proper leadership but may stray on unfortunate paths unless this is provided. Society is craving for a Moses to lead it out of the wilderness. Where is the directing influence to come from in medical matters if not from organized medicine? Comparatively, we are a small army, but our influence is greatly in excess of the proportion of our numbers. We must have a definite policy and we must be our own Moses.

It is a duty of our profession, to insulate the members from destructive forces, but we perform a greater service to the public by assisting them in the preservation of whatever is beneficial to them. Let us examine all general situations very closely. We have always been a great factor in the spread of health knowledge. The noble physician, even single handed, is a great instrument for preserving social morality and for providing proper ac-

tion for those with whom he comes in contact.

Recently President Roosevelt said of the medical profession—"From it we have learned lessons in the ethics of human relationships—how devoted to the public good, unselfish service, never ending consideration of human needs, are in themselves *conquering forces*."

You members are an absolutely necessary part of the whole scheme. Arise to your full

length pattern and hold your profession in its proper place through this peculiar phase of human existence. Circumstanced as you are or may be by economic problems, be inspired by your heritage of the ideal of your profession, and thrilled with a just passion to continue an individualistic practice, to sense fully your responsibilities to society, and to uphold the dignity and leadership of the profession.

PHYSICIANS AND OTHER HEALTH AGENCIES

By THOMAS B. LEE, M.D., Camden, N. J.

The Presidential Address before the Camden County Medical Society, October 2, 1934

With the Camden County Medical Society functioning smoothly and efficiently, the work and responsibility of being President have been reduced to a minimum. We are tempted, however, to leave with you a few thoughts regarding some agencies with whom we have had to deal during our year of office.

LAY HEALTH AGENCIES

Physicians must give thought to present day medical problems. Unfortunately, *I think at times*, physicians are not the only ones interested in the sick; and especially the *needy* sick. All over the land, societies, committees, bureaus, foundations, and what not, have sprung up to cope with these problems. Most of them are honest and sincere. All of them feverishly anxious to do something at once. Facts and conditions are only partly studied, broad underlying principles are ignored, often sentiment rather than science is adamant, and there is great danger that the physician who has been carrying this burden for hundreds of generations, and who will be still carrying it when all the "shootin's over", will be pushed aside to the detriment of the cause, for he and he alone can best lead in solving these problems.

It would be tragic, indeed, not only to the medical profession but to the interest of the sick themselves to have any agency come between the physician and his patient. It is unnecessary; it is undesirable; it is obstructive. This land in the last few years has been *commissioned* and *bureaucrated* to death, the members

of said commissions drawing comfortable salaries, spending much time in efforts to perpetuate the body of which they are members, and understanding little or nothing of the practical details of the problems in hand. The care of the indigent sick so long carried alone by the medical profession is properly a burden of the local government just as are the care of the water supply, fire protection, police department, etc. And the doctor fits into the problem just as does the groceryman who feeds them or the policeman who protects them, and should be paid properly for such services.

The present emergency is met fairly well by the E. R. A. arrangements, and with all its imperfections it has given fair satisfaction. This, however, is temporary; and as its need passes away, we must be prepared to meet similar if less urgent problems in a better way.

DRUG HOUSES

We often wonder if physicians realize how much they have been used to introduce semi-proprietary medicines to the public. It would appear that they have been of more use to the commercialists than all the newspaper advertising.

It happens something like this. A dapper, pleasant, well-dressed and well-mannered gentleman carefully selected for the part calls upon the doctor. His stay is brief and pleasant, he leaves a few samples attractively put up on the doctor's desk and politely takes his leave. Sooner or later, usually sooner, the

doctor passes out said samples plainly and attractively labeled to the patient. He thus puts the stamp of his approval on this product and passes it along to the trusting patient. Now what does the trusting patient do? If he thinks the medicine helps, and he usually does for such is the psychology, he goes to the cut-price patent medicine store and purchases a bottle, often in addition advertising the product to his friends. This little game is deliberately planned by the manufacturer, who isn't interested in the doctor at all but in his own profits. The doctor is the goat. Now is anything more dumb? Some of the best paying proprietary medicines today have been thusly presented to the public.

Another well thought out and clever scheme is to send postals to physicians which arrive at regular and frequent intervals and which purport to be case reports. This eventually fixes in the victim's mind the name of a certain mixture. A glance at the formula, in this particular instance a combination of endocrine substances, would instantly disclose the fact that the quantities of the drugs are so minute that at least 20 to 30 tablets would have to be taken t.i.d. to produce any physiological reaction whatever. Has this scheme been successful? It has! The schemer has become a millionaire, the patient victimized, and the doctor has become the goat.

The better druggists are making a great effort to supply the patients with good drugs in attractive forms and at fair prices. They should be encouraged and supported. It is true that there is a great discrepancy in the prices charged for prescriptions in the different pharmacies; but if discretion is used in the choice of a druggist, and I see no impropriety in such discrimination, the patient is very fairly treated. Certain it is that if our patients cannot be helped by our well-known pharmacopeal drugs, they cannot be helped by these expensive preparations of the same drugs, often in ridiculous combinations even though they be so cleverly advertised.

It must also be remembered that careless prescribing, as in the case of the barbiturates, in which patients have been advised to go down to the drug store and get a bottle of this

or that, has resulted in the passage of a law making these drugs obtainable *only* on prescription—rather a drab commentary on one of our own weaknesses. It might also be noted in passing that the law, which is a good one, was passed in this and many other states through the efforts of one of the great daily newspapers. Somebody stole our thunder while we were napping.

FREE HOSPITALS AND DISPENSARIES

It is true that in normal times hospitals and their dispensaries take away a great deal of income that should go to the family physician. In such times as we are now passing through, however, this is not the case. In a careful survey recently made in Philadelphia by agencies not hostile to the profession, and in which a total of 1000 dispensary cases were carefully investigated, less than 5 per cent were found to be able to pay any part of necessary medical care; and less than one-half of one per cent to pay all of it.

The hospitals, by the installation of social service workers, have earnestly tried to eliminate all of the "able to pay" cases. Curiously the boards of managers of the hospitals, having the lay point of view, have been in many instances inclined to receive part-pay cases in the dispensaries, thereby helping to defray expenses. So we find hospitals making dispensary charges of ten cents in some cases—as much as fifty cents in others. We regard this as bad practice viewed from any angle. It leaves the patient with the impression that he is paying for his treatment, and this is the wrong relationship to exist between a free dispensary and its patients.

CLINICAL RECORDS

It is to be regretted in the interest of the sick that there is a hiatus in the continuity of medical service rendered a patient who passes from the hospital into the hand of the family physician. This applies especially to chronic cases. Often a great deal of study, laboratory and otherwise, is done, the details of which never become afterward available in the patient's later care. Of course, the ideal plan would be to send out with each such patient an abstract of the hospital records; but since

this would entail extra expense in clerical help and supplies, it is obviously impossible with the present universal condition of unbalanced hospital budgets.

The hospital records, however, of any patient coming under the care of an *ethical* physician are open to that physician. Hospitals should be and usually are glad to give cordial and helpful information of this kind. A closer coöperation of this character would, I am sure, result in benefit to physician, hospital, and patient. Most hospitals would like to be relieved of the large dispensary service; and I am sure when conditions approach the normal some plan can be evolved whereby the family doctors can do much of this work, possibly at certain convenient hours for a portion of his usual fee to the mutual advantage of all concerned.

DEMANDS OF CIVIC ORGANIZATIONS

Civic organizations, such as the Parent-Teachers' Associations, are educating the people to demand health examinations and pre-

ventive immunizations, beginning with children in public schools.

Periodic health examinations can be built up into a legitimate and paying practice. They increase the physician's income, are of great benefit to the patients.

Prophylactic medication is constantly increasing its scope. It is valuable to the people, and all doctors should keep posted up to its last minute of progress. These problems of prevention must receive careful thought on the part of our profession else other agencies will usurp the leadership which we alone can carry on intelligently. Also, these matters are not only vitally important to us, but to our successors as well.

To quote from a sacred source and paraphrase slightly without sacriligious intent—"Some things are important; think ye on these."

I wish to thank you for your coöperation and courtesy during the past year; and may no one arise and move that these rambling remarks be sent to the State Journal for publication.

THE FUTURE OF MEDICAL PRACTICE

By WATSON B. MORRIS, M.D., Springfield, N. J.

The Annual Address of the President of the Union County Medical Society, on October 10, 1934

This has been one of the most active years in the history of the Union County Medical Society; and in spite of all our economic problems it has been a most interesting and instructive one.

Our medical ills are far from cured, but I feel we can report progress. My remarks on the "Future of Medical Practice", which is the topic of my paper, are formulated from many articles printed, discussions among my medical associates, and observations made during this period of economic distress.

COSTS OF MEDICAL SERVICE

The prosperity and future of our nation lies in having the consumer get the most for his dollar; and in that regard the cost of medical

care is a fundamental factor. While the *science* of medicine has progressed at a rapid pace, the application of its *business* principles is still in the ox-cart stage.

Statistics show that 65 per cent of the earnings of individuals of moderate incomes are paid out for food and shelter; and the remaining 35 per cent for other necessities of life, including medical care. Yet too many physicians are underpaid. Undoubtedly some fortunate doctors, mostly specialists, make large incomes, and some fortunate families have little sickness to worry them; and so the actual cost would not be too high for the population as a whole, and the aggregate income of the physicians not too small, if we could devise a plan whereby we could take less from the few

and a moderate fee from the many, thereby placing the profession at large on a more even keel.

As physicians, we keenly realize that illness is seldom anticipated and is rarely included in the family budget. From these facts I am led to believe that the profession must in some way organize to put medical care on a sound business basis that will insure us a living wage and the approval of the public.

The greater service which the medical fraternity is so constantly striving to perform requires re-organization; and it is our duty to find the way and sell it to our people before some plan is made for us.

It is a sad commentary that the income of the average physician is barely in excess of \$3000.00, although a capital investment of about \$25,000.00 is necessary to complete one's education for the practise of medicine.

As physicians, we have but one thing to sell the public, and that is *health*; and with the proper organization that has produced such wonderful strides in the scientific world, the same fact-finding methods will produce successful business results at a much lower cost to the patient and increased returns to the profession.

Presuming this to be true, let us analyze how this can be done and so stimulate effective interest in health, which is our greatest national asset.

GROUP PRACTICE

The *decentralization* of physicians is probably the one item which heaps up the cost of medical care; and unnecessary *hospitalization* still further adds to the burden.

It has been definitely proved that a hospital really makes money on a patient during the first week of his stay; and after that he is likely to prove a liability, because no provision is usually made for a protracted illness. Hospitalization only when really necessary would be a big step in reducing the cost of medical care.

We are living in an age of mass production and mass distribution; and believe it or not, the practice of medicine will of necessity be

based on a fundamental plan of giving the utmost for the least cost.

That the medical profession is a humanitarian business is no reason why it should not be a profitable one. The old tradition has been to serve first, and worry about fees afterward. This was as it should be. However, we are now living in a very different age, and with the demands of the public today, we must adopt more business-like methods.

I firmly believe that in the not too distant future we will see a national organization of some type, which will provide the average citizen the benefits of expert diagnosis and the best preventive and curative advice and care at a price within his means. As a matter of fact, this already is in force in many of the large cities.

In my opinion, some form of *group practise* will be the answer; and the key to the whole situation should be the family physician.

It is true, the family physician should be capable and up-to-date in his methods of diagnosis; and if alert and honest with himself and his patient, he will seek the help of the specialized group to assist him in solving special problems. Doing this at a fee within the means of the patient would bring us nearer the ideals of medicine and add to the longevity and happiness of our people. If this could be accomplished, the profession would be assured of proper compensation, and our patients would be relieved of the financial worries that serious or prolonged illness causes under our present plan of practise. I am satisfied that, if the medical profession would organize along some such plan, government insurance and state medicine could be avoided.

It is our earnest desire to maintain a healthy race of people, since by their work they increase the buying power of the dollar, and so aid us to get back to the prosperity era.

I have been told that group medical care offers a superior service at a radically reduced cost, and I believe that to be true under a centralized plan.

If that be so, we hope to see the day when by that or any other organized plan, we will be able to provide the rich or poor with the

highest type of medical care that can be promptly paid for.

Admitting all this as possible, how can it be accomplished?

I believe it is our duty as members of the American Medical Association to group our societies, and demand some action on the part of the national organization. We recommend that they provide executive offices in Washington just as every other organization does when they want action for or against legislation of interest to the medical profession.

Let us not forget that success requires *organization*; and it is my hope that in the near future medical care will be given a recognized share of the consumer's dollar, and that our high ideals will be the guiding force in bringing about some necessary economic change.

SPECIFIC SUGGESTIONS

At this point let me suggest a few facts which to my mind are essential if we are to accomplish our aims:

1. Let us make an intensive study of the various forms of group medicine.

2. Let us obtain better control of legislation that is adverse to medicine by seeing to it that our strength as a profession is felt among those we elect to political office. This we can and will do through our County and State Professional Guilds.

3. Let us make better and more intimate contacts with the public either individually through the use of the follow-up idea, or collectively by means of health educational publicity.

I wish to lay stress on the fact that, with the improvement in business conditions, we

are to be challenged for our past inertia; and this should be a stimulant to our initiative.

The greater benefits of preventive medicine are too apparent for us to overlook them, or to permit the public to continue in ignorance of them; in other words medicine must end its policy of passiveness and we must have a new deal.

If prosperity does return bringing a greater call upon our services, it will certainly set the stage for a renewal of state medicine agitation by millionaire foundations, and will pave the way for further politically-minded legislation detrimental in its final effect to both the public and medical profession. Therefore, every unit of organized medicine down to the smallest county society should prepare for action and make a supreme effort to block it.

However, in spite of all our anxieties we must decide in our own minds that the situation is far from hopeless, provided we possess the power and foresight to take the initiative in shaping the destiny of our profession.

In conclusion, let me say that this can be done by giving the officers of your society not only your presence, but also your help.

Be not only a *physician*, but also a real *member of the organized profession*; and remember that the success of any group depends about one-tenth upon the zeal of its officers and nine-tenths upon the energy of its individual members.

I am sure the strength-in-unity action will be all-important in the months to come. Make it your moral duty to attend regularly your local, county, and state meetings; to elect officers who are progressive; and then support them 100 per cent in all definite, constructive issues adopted. By so doing much will be accomplished.

STATE SOCIETY ACTIVITIES

CONFERENCE OF COUNTY SECRETARIES AND REPORTERS

The Annual Conference of County Secretaries and Reporters was held in the Hotel Stacy-Trent, in Trenton, on Wednesday, November 7, 1934, beginning at noon and continuing until five o'clock. There were present:

From The Medical Society of New Jersey:
President, Lancelot Ely
Second Vice-President, S. T. Snedecor
Chairman of the Publication Committee,
H. C. Barkhorn
Executive Secretary, LeRoy A. Wilkes
Editor, Frank Overton.

County Secretaries:

Frank W. Pinneo, Essex, Chairman of the Conference
A. D. Hutchinson, Mercer, Secretary
R. S. Gamon, Camden
E. C. Lyon, Cumberland
T. M. Brennock, Hudson
W. W. Hall, Passaic
L. B. Armstrong, Union

County Reporters:

E. S. Corson, Cumberland
E. L. Wood, Essex
J. N. Connell, Hudson
H. B. Diverty, Gloucester

The program of the conference had been carefully prepared by Drs. Pinneo, Hutchinson and Wilkes, on practical subjects of *society administration*, with Dr. Wilkes introducing the subject of the scope of the work of the County Secretaries, and Dr. Overton, that of the Reporters in a brief, concise manner. The Secretaries and Reporters occupied most of the time in *expressing their reactions to the plans, and making valuable suggestions of their own*. The conference was of peculiar interest and value, for all entered into the discussions freely and with a spirit of coöperation. There was an entire absence of critical comments; and all the suggestions were constructive and will undoubtedly lead to a better understanding of the common objectives to be attained by the County Secretaries and Reporters, whose activities center around the central administrative offices of the State Society in Trenton. The discussion brought out the various methods followed by local representatives in carrying on their work in a manner adapted to their own communities, but all seek-

ing to accomplish the objectives which had been adopted by the House of Delegates.

ADDRESS BY PRESIDENT ELY

The conference was opened by a brief address by Dr. Ely, President of the State Society, who spoke on the importance of the conference since it is composed of leaders who are in a favorable position to understand the relations of practicing physicians and medical societies to other health workers engaged in promoting efficient medical services to all the people.

"There are always degrees of ability and tastes among the members of any group, and the County Medical Society offers an opportunity for the exercise of every kind of medical talent. Those who are social-minded are always found at medical meetings; and they are the leaders to whom the individualistic doctor looks for advice, especially when he is in difficulty. One great object of this conference is to explain some of the practical methods by which the county societies may carry out the projects of the State Society."

THE CENTRAL OFFICE

Dr. Wilkes, Executive Secretary, outlined the work of the central office, in which communications from the county secretaries are received and from which information is sent almost daily.

Dr. Overton described the method of the editorial department in obtaining and preparing the reports received from the reporters for publication in *The Journal*.

The description of the two departments of the central office—the secretarial and the editorial—revealed a high degree of coöperation between the state and the county societies in carrying on the activities of the organized medical profession of New Jersey and presenting the work accomplished, and the objectives of the future. The addresses emphasized the importance of the work of the county secretaries and reporters, and their essential rôles in the county societies where all the activities of the State Society center. The State Society is in fact a federation of the twenty-one component societies; and its accomplishments are the sum of the achievements of the local organizations and their individual members.

The topics discussed in the morning session were the two State Society projects of *diph-*

theria immunizations, and the *Emergency Relief Administration*, from the point of view of both the Medical Society of the State and the county societies.

THE PUBLIC HEALTH HOUR

Dr. Wilkes outlined the principles of the project of the "Public Health Hour". He said that the methods of diphtheria prevention must be adapted to three age groups:

1. Adults. Most adults are immune to diphtheria, and only a small number of cases and fewer deaths occur from the disease in this group.

2. Children in the younger school ages. Their immunization has been assumed by the school authorities and the Parent-Teachers' Associations; but physicians as an organization are taking an increasing interest in the project and are giving an increasing number of immunizations in their offices. Somewhat less than fifty per cent of diphtheria deaths in New Jersey have been among children of school age; and the percentage is constantly dropping at the rate at which children are immunized.

3. Children of the pre-school age. This group supplies 55 per cent of all deaths from diphtheria. Immunizing all school children will prevent somewhat less than half of diphtheria deaths; the prevention of the other half is the responsibility of family doctors, although the Parent-Teachers' Associations are conducting campaign to immunize those children who are about to enter school for the first time. But the immunization of children under the age of four will devolve principally upon the family physician. If the immunizations are given to very young children, there will be no need of school clinics; for all will be immune when they go to school.

THE PRESCHOOL RECORD CARD

Dr. Corson spoke on the need that the mother of every new-born child should receive instructions from her family doctor regarding the time when the child should receive its immunizations. The mother now usually gets most of her instruction and inspiration in child care from the public health nurse or the Parent-Teachers' Association.

Dr. Wilkes displayed and explained the pre-school record card of the State Medical Society that was printed on page 546 of the September Journal. He also showed a birth record card carrying the seal and imprint of the State Society that is furnished free by a supply house to physicians who apply for it

through the State Medical Society. Both forms of cards are constant reminders to the mother to have certain health services given to her child at specified intervals.

THE E. R. A. PROJECT

Dr. Spencer T. Snedecor, Chairman of the Advisory Committee to the Emergency Relief Administration, spoke on the more recent developments of the relations of practicing physicians to the State Administrators. The doctors are becoming familiar with the forms of reports which must necessarily be rendered to the State officials in order to obtain their pay from the state. Dr. Snedecor mentioned two defects, both of which the committee is remedying:

1. The bureaucracy that goes with any state-wide plan of administration. This is being remedied through the continual growth of a mutual understanding between the physicians and the E. R. A. officials.

2. Inequality of distribution of the funds, some counties getting less than their quota, and others more. This is being remedied by mutual understandings and concessions.

The Secretary of the County Society is the "key" man in all the county activities, including relief work. He has a duty in giving advice regarding the personnel of the County Administrative Council—to get a representative of the medical society appointed on it. He is also the best judge of the personnel of the County E. R. A. Committee. He also has a responsibility to see that the committee functions properly, and holds meetings sufficiently often to attend to the business promptly. A perfect plan of action and coöperation has not yet been attained, but progress is being made as the need becomes evident.

Among the recent changes in the E. R. A. procedure are the following:

1. A simplification of the method of giving authorizations for medical service—the first authorization being for one visit; and after a diagnosis and prognosis are made, authorization for five calls may be given.

2. No doctor to receive more than \$250 from E. R. A. funds in any one month.

3. A simple receipt signed by the patient will be accepted as sufficient evidence of medical service delivered.

4. If a physician receiving a salary applies for enrollment on E. R. A. lists, he shall be considered by the committee as an individual, and his enrollment will be decided on the merits of the case.

Dr. Snedecor also said that the secretary of

the county society can render service of peculiar value by keeping himself informed of the details of local E. R. A. service, and giving advice when complaints are made.

Concerning the self-regulation of conditions of E. R. A. service, Dr. Snedecor said that the doctors could have the control to the extent of their agreement regarding conditions. The State E. R. A. Committee was inclined to grant exceptions to their rulings in exceptional instances, as for example, one doctor who treated over 200 E. R. A. patients in one month because he was in an exceptionally poor section and the pay of his practice which ordinarily brought him a comfortable living had dropped to almost nothing. The E. R. A. Committee considered this to be a very exceptional case and granted him full pay for all E. R. A. cases.

Dr. Snedecor's talk and the answers which he gave to questions will be of assistance to secretaries in dealing with medical relief problems which New Jersey seems to be doing better than any other state.

THE EXECUTIVE SECRETARY

Dr. LeRoy A. Wilkes, Executive Secretary of The Medical Society of New Jersey, spoke on the work of the central office of the State Society. He described it as that of managing the machinery of communicating with the County Societies, largely through their secretaries. The kinds of services rendered by the central office are:

1. Administration and records.
2. Information—receiving, classifying, issuing reports and notices.
3. Coöperation and helpfulness—mimeographing, sending notices, giving advice.

Everything that concerns the office of the county society is the concern of the state office.

The facilities of the office of the State Society are at the disposal of the county societies. For example, the central office will send out notices for the smaller county societies if the society will supply the stationery and envelopes, and also pay four cents for each plate made for the addressograph.

THE COUNTY SOCIETY AND ITS RELATIONS TO LAY HEALTH ORGANIZATIONS

Each County Society is the *service agency* for its members, especially in their relations to civic bodies and the community. Physicians act in their individual capacities when they treat their individual patients. They should act in the name of the medical society when they give advice or service to civic bodies or the community.

The lay health organizations, such as Parent-Teachers' Associations, should be taught to consult the County Society when the service or advice of a physician is needed. The rule is:

- Individual doctors for individual patients; and
- County Societies for advice or service to civic bodies, or lay health organizations.

There is always a representative available to speak or act in the name of the County Medical Society. Community groups should keep within the scope of their proper functions, and should call upon the organized medical profession for aid and advice in the solution of all health problems in their work.

Every member of the County Society should recognize that he has a dual rôle:

1. That of a private physician to his patients.
2. That of a representative of his county in civic activities of the profession.

Each organization—civic and medical—should recognize the scope of its work. This would involve the County Society acting as a unit in furnishing health services to the *community* in distinction from the individual patients who seek the personal services of a family physician.

A HEADQUARTERS FOR EACH COUNTY SOCIETY

Medical leadership in the community will soon require that every county society shall have its own home and office with definite hours when the secretary or his representative may be reached. At present the secretary might state an hour when he can be reached by organizations who will turn to the medical profession for advice. This hour might be stated on the official stationery of the secretary.

Some form of organized medical effort is being demanded by the public. We have the opportunity to experiment and develop the type of organized effort that will be suited to the need and convenience of both the physicians and the public.

TIME OF ASSUMING OFFICE

Experience has demonstrated the need that the terms of office of the County Society officers shall be synchronous with that of the officers of the State Society, who now assume office at the close of the Annual Meeting of the State Society. The State officers now begin in the early Fall to carry out the policies established by the House of Delegates, and then just as the activities are under way, the county society officers change, and a new set of offi-

cers and committees must assume charge of the work.

There was considerable discussion regarding possible methods of making the terms of all officers of the county societies begin and end at the same time as those of the State Society.

ANNOUNCEMENTS OF COUNTY SOCIETIES

It is extremely desirable that copies of all announcements and bulletins and publications of county societies be sent to the central office of the State Society. The State Society should have the information contained in them available both for arranging for the activities of the State officers, and also for the information of other County Societies.

The address of Dr. Wilkes gave a clear picture of the means for securing the best coordination of all the units of the medical profession. The first step in the attainment of that end is a clear *diagnosis* of present conditions; and the next is the formulation of a practical *plan* for their improvement.

THE JOURNAL

The relation of The Journal to the individual members, the County Societies, and the State Society, was described by Dr. Frank Overton, the Editor. The Journal is the depository of the official records of the societies. While the records are received and filed in the central office where they are available for current use, the Journal is almost the only source where the essential records of the past may be found, summarized and indexed in permanent form and ready for consultation. Every day the officers consult the files of The Journal for information regarding former projects and the methods used in carrying them out.

It is an interesting fact that the same projects and problems of the State Society recur in cycles of five years or more. This repetition of forgotten activities would not occur if the Journal were consulted. An example of the value of former records is that in connection with the time of the 1935 Annual Meeting. The question arose as to the probable effect which the meeting of the American Medical Association to be held on June 10-14, 1935, in Atlantic City, will have on the meeting of the State Society which normally would be held in June in Atlantic City. Considerable search of the former numbers of The Journal was required to discover that the last meeting of the A. M. A. in Atlantic City was held in 1925, and was followed three weeks later by a State Society meeting at which it was recorded that the attendance was greater than

at any former meeting. This was valuable evidence in enabling the officers to decide upon the time of holding the next annual meeting.

PUBLIC RELATIONS OF PHYSICIANS

The Medical Society of New Jersey is the oldest medical society in the country, having been founded in 1766. The chief object of the medical societies for over a century and a quarter of their existence was the promotion of a knowledge of scientific medicine among its members; and that object is still dominant today. The department of scientific medicine is still the largest in The Journal; and one standard of the acceptance of an article is that it shall have been read before a recognized medical society where it may be discussed and its contents approved by the confreres of its author.

PRODUCTION AND DISTRIBUTION OF MEDICAL SERVICES

Medical service in these modern days is becoming recognized as a *public utility* which shall be available to every person, no matter where or how he lives. There have therefore arisen acute problems regarding the *distribution* of the services.

The medical profession of New Jersey *produces* medical service of the highest order; but its distribution requires the coöperation of numerous other groups. The most desirable form of service, that of private practice among the well-to-do, requires the coöperation of hospitals and laboratories equipped and maintained by groups of philanthropic citizens.

The services to the poor require the coöperation of governmental officials, such as those in the Emergency Relief Administration and welfare departments.

Sanitation and the control of communicable diseases require the coöperation of official departments of health manned by experts in the employ of the state.

The great field of *preventive medicine* requires the coöperation of lay health organizations and civic groups, such as Parent-Teachers' Associations, and tuberculosis organizations.

Physicians must work with all these groups in order to distribute and deliver their services to large groups who otherwise could not obtain them. The Public Health Hour is an example of service promoted by The Medical Society of New Jersey, and sponsored by the county societies.

The vast field of preventive medicine has been preëmpted by lay health organizations, who are yet dependent on individual physicians

for the actual delivery of the services to the individuals needing them. But within the last decade the medical societies have been increasingly active in asserting the right and duty of physicians to direct and control the methods of delivering all forms of medical services to all classes of people.

The public relations of physicians have therefore become major topics of discussion in every medical society; and The Journal has become the principal depository of the records of the activities and achievements of physicians in their relations to other groups engaged in the delivery of medical services.

COUNTY SOCIETY REPORTERS

When The Medical Society of New Jersey established The Journal in 1904, it established the system of reporters in every county, whose duties are similar to those of reporters of other periodicals. This system has worked so well that there has never been a suggestion of changing it.

The conference devoted considerable time to means and methods of promoting the efficiency of the system of reporting the activities of the county societies. One suggestion that was discussed at some length was that the official reporters be made ex-officio members of the House of Delegates. It was voted to request that the arguments for the plan be sent to every county society.

PRESERVING THE JOURNALS

The Editor reported on the project of supplying every member of the State Society with a box which would hold the Journals for a year. The box would be placed on the desk or library shelf of the doctor where it would be readily accessible, so that any current journal could be readily reached for reference. The

need for such a system is abundantly demonstrated by the fact that frequent requests come to the central office for information which has been published in The Journal, but is not available to the inquirer because the Journal has been misplaced and cannot be found.

A sample box was shown at the conference that could be supplied at a cost of twenty-five cents. The Trustees had considered and approved the project in a general way, and its adoption will depend on the response of the members to the proposition. One plan that was suggested was that it should be supplied through the county society secretaries.

On motion of Dr. Earl LeRoy Wood, Reporter for Essex County, the conference approved the plan that was suggested for supplying the boxes to the members.

Dr. Pinneo made the additional suggestion that provision be made to bind each year's volume of The Journal at a nominal cost.

A PRACTICAL CONFERENCE

Many other suggestions regarding the work of the secretaries and reporters were made and duly recorded in the stenographic reports of the conference. These additional suggestions will be fruitful sources of subjects for editorials and for addresses at county society meetings. It was most gratifying that all the discussions were constructive and indicated a sincere desire to promote the efficiency of The Medical Society of New Jersey and its component societies.

The officers of the conference elected for the coming year were: Dr. George T. Tracy, of Burlington County, Chairman; and Dr. A. D. Hutchinson, of Mercer County, Secretary. The next meeting will be held at a time and place to be determined after consultation with the officers of the State Society.

STATE MEDICAL ADVISORY COMMITTEE TO THE E. R. A.

A meeting of the State Medical Advisory Committee to the Emergency Relief Administration was held in Newark on November 6, 1934, beginning at 4:40 p. m. Those present were: Drs. Snedecor, Fithian, Hawkes, Schlichter, Sherman, Mr. Coleman, Mr. Rasmussen, and Dr. Wilkes, Secretary.

Dr. Snedecor, Chairman, called the meeting to order and asked Dr. Fithian to outline his plan to control the authorization of medical service in Middlesex County. He stated that there is a feeling at times that favored physi-

cians profit most from E. R. A. participation, but there is no proof of this.

Under Dr. Fithian's plan:

1. The patient goes to the physician directly.
2. The attending physician telephones the Medical Referee for authorization which is furnished through the Clerk (E. R. A.) in the office of the Referee.
3. The Referee authorizes the number of visits which may be made without further authorization.

4. The bills are rendered as heretofore subject to the approval of the Medical Advisory Committee of the County Medical Society.

5. The E. R. A. pays the approved bills.

Dr. Fithian's plan was approved by both the E. R. A. and the Medical Advisory Committee for trial.

The criteria to be used for judging the merits and practical operation of Dr. Fithian's plan are to be as follows:

1. Cost.
2. Good medical service to the patient.
3. Satisfaction in County Medical Societies and the E. R. A.

Dr. Ely asked for information regarding payment for services rendered in Somerset County. Mr. Coleman will investigate.

Patients may sign on a prescription blank or on a receipted bill for services received from a physician under the E. R. A.

Old-age relief cases are not paid *directly* by the E. R. A. (only through subsidiaries paid to Old Age Relief Committee).

The delay in payments for relief cases is often due to changes in personnel in the E. R. A.

A letter of renewal of the E. R. A. agreement was received from Mr. Compton by Dr. Snedecor. The House of Delegates of The Medical Society of New Jersey in 1934 had authorized the State Medical Advisory Committee to renew the E. R. A. agreement for 1935 at its discretion.

"M-30" forms are not necessary, but diagnosis and visits must be given in each case in writing, before bills are paid.

Dr. Hawkes said the hospitals do not follow the instructions as to "authorizations within five days".

In Essex County emergency cases are admitted without authorization, but all other cases must be authorized before admission.

Dr. Snedecor requested the consideration of the trial program of mileage allowance in Burlington County. Approval of E. R. A. is withheld at this time.

Dr. Schlichter moved that the request of Burlington County for mileage at 10 cents a mile be tried out experimentally under conditions stated by the Burlington County Medical Society. Dr. Hawkes seconded the motion. Unanimously approved.

Dr. Hawkes stated that at the July meeting \$250 was made the maximum amount which any physician can receive in any one month for E. R. A. services. Essex County Medical Society and the E. R. A. Advisory Committee propose \$150 for the maximum (January 1, 1935).

Dr. Snedecor said that Dr. Lewis in Camden County proposes a maximum of \$300, and suggests that the \$250 maximum be tried out further.

Dr. Snedecor spoke for Dr. Watts of the Mercer County Medical Society regarding city physicians. The E. R. A. ruled that "any physician who is excluded by legal technicalities may appeal to his County Medical Society; and if the Society approves, the case may be referred to the E. R. A. (Mr. Coleman), who will consult the State Medical Advisory Committee for approval; and then the E. R. A. may give its sanction".

Costs for services during July, August and September for the State now are available.

Dr. Snedecor stated that if a county shows actual increase in cost, an explanation should be requested.

Dr. Snedecor was instructed unanimously by the Medical Advisory Committee to request a hearing in Washington before the U. S. Compensation Committee on P. W. A. cases. A member of the E. R. A. staff is to be present.

Mr. Coleman cited previous P. W. A. cases of flagrant abuse in Newark; and on the basis of this evidence certain members of the Essex County Medical Society were taken off the list by that Medical Society.

The influence of politics in Atlantic City on the appointment of examiners in "work for relief" program was cited at the request of the Atlantic County Medical Society.

Mr. Coleman read the minutes of the County Medical and Relief Committee.

No colored doctors were provided on the recommended list. Howard asked for appointment of colored doctors which was refused but the appointment of colored physicians was made anyway. The proper procedure would have been to appeal to the State E. R. A. and the State Medical Advisory Committee, and let them settle the matter.

That all medical appointments shall be made by the County Medical Society Advisory Committee is a sound principle to be insisted upon.

A letter urging the appointment of a physician on each E. R. A. County Advisory Committee is to be sent out by the Executive Secretary.

The State Medical Advisory Committee requested a plan of decentralization of the Emergency Relief Administration.

A letter was received from a doctor in Middlesex County with reference to cases of acne requiring x-rays. The solution of the problem by local administrators and physicians was recommended by the E. R. A.

FEDERAL PLANS FOR ECONOMIC SECURITY

The Federal Administration is about to supplement and ultimately replace its vast activities in economic *relief* with those of *prevention*. While its general plans and a very limited personnel have been known for some time, the definite announcement of the administrative committees and the scope of their duties was first issued in the morning papers of Sunday, November 11, 1934. The following information was obtained from the New York Herald Tribune:

COMMITTEE ON ECONOMIC SECURITY

The central organization for devising and operating the plans of the administration centers in the *Committee on Economic Security* which was created some time ago, and consists of the following persons appointed by executive order:

Miss Frances Perkins, Secretary of Labor, Chairman
Henry Morgenthau, Jr., Secretary of the Treasury
Homer S. Cummings, Attorney General
Henry A. Wallace, Secretary of Agriculture
Harry L. Hopkins, Federal Relief Administrator.

ADVISORY COUNCIL

An *Advisory Council* of nineteen members is named in the present announcement of the President, for the purpose of giving "advice and counsel in developing a program for unemployment insurance, old age security, and adequate health care". Its personnel is as follows:

Frank P. Graham, President of the University of North Carolina, Chairman.
Gerard P. Swope, President General Electric Company, of New York.
Morris E. Leeds, President Leeds & Northrup, of Philadelphia.
Sam Lewisohn, Vice-President Miami Copper Company, of New York.
Marion B. Folsom, Assistant Treasurer Eastman Kodak Company, of Rochester.
Walter R. Teagle, President Standard Oil Company of New Jersey, of New York City.
William Green, President American Federation of Labor, of Washington.
George M. Harrison, Grand President Brotherhood of Railway and Steamship Clerks, of Cincinnati.
Paul Scharrenberg, Secretary-Treasurer California State Federation of Labor, of San Francisco.

Henry Ohl, Jr., President Wisconsin State Federation of Labor, of Milwaukee.

Belle Sherwin, former President National League of Women Voters, of Washington.

Grace Abbott, University of Chicago and former Chief U. S. Children's Bureau, of Chicago.

Raymond Moley, Editor of "Today" and former Assistant Secretary of State, of New York.

Paul Kellogg, Editor "The Survey", of New York City.

George H. Nordlin, Chairman, Grand Trustee, Fraternal Order of Eagles, of St. Paul.

George Berry, President International Printing Pressmen and Assistants' Union of North America.

Josephine Roche, President Rocky Mountain Fuel Company, of Denver.

John G. Winant, Governor of New Hampshire.

Louis J. Taber, Master National Grange, of Cleveland.

MEDICAL ADVISORY COMMITTEE

Miss Perkins has also announced the appointment of a *Medical Advisory Committee* of ten members for the "study of economic problems arising from illness in families of the low income group". The personnel of this committee is as follows:

Dr. Harvey Cushing, Harvard University, Boston, Mass.

Dr. Stuart R. Roberts, Professor of Clinical Medicine at Emory University, Atlanta, Ga.

Dr. George Crile, Cleveland Clinic Hospital.

Dr. Thomas Parran, Jr., New York State Commissioner of Health.

Dr. James D. Bruce, Ann Arbor, Mich.

Dr. Rexwald Brown, Santa Barbara, Calif.

Dr. James Alexander Miller, Professor of Clinical Medicine, College of Physicians and Surgeons, New York.

Dr. Walter L. Bierring, President American Medical Association, of Des Moines, Iowa.

Dr. Robert B. Greenough, President American College of Surgeons, Boston.

Dr. George M. Piersol, Past President, American College of Physicians, Philadelphia, Pa.

A three-day session of the *Advisory Council* was opened on November 14, with an address by President Roosevelt. That part of his address relating to health was as follows,

according to the New York Herald Tribune of November 15:

"There is also the problem of economic loss due to sickness—a very serious matter for many families with and without incomes, and, therefore, an unfair burden upon the medical profession.

"Whether we come to this form of insur-

ance soon or later on I am confident that we can devise a system which will enhance and not hinder the remarkable progress which has been made and is being made in the practice of the profession in medicine and surgery in the United States."

Dr. Olin West and other representatives of the A. M. A. were present by invitation.

HEARING ON THE PHYSICIANS' LIEN LAW IN ATLANTIC COUNTY

Atlantic was the first county to hold a hearing before its county judges on the Physicians' Lien Law. The Atlantic County Medical Society acted promptly after the schedule of fees pertaining to the Physicians' Lien Law was returned by the State Committee which formulated it. The schedule as proposed by the State Committee as a working basis for the various counties, was adopted by our society in its entirety, at a special meeting held on August 10. It was then filed at the County Seat, with notices in the newspapers that such action had been taken, and that there would be a hearing after 30 days had passed, and at the discretion of the county judges.

A meeting was arranged to be held before Judge Warke and Judge Corio in the Guarantee Trust Building, October 15th, 1934, and a very good representation of the Atlantic County Medical Society was present. The mat-

ter was presented to the court by Dr. David Allman, President of the Society. State Senator Siracusa spoke, explaining to the court some of the difficulties that had been discussed in the Legislature; and said that this fee schedule showed the results of a good deal of work by the Committee, and that he was sure that the Atlantic County Medical Society was fair in presenting this schedule.

There was practically no opposition shown at this hearing. In fact, there were but two lawyers and one insurance representative present. There being no opposition expressed, the court ruled that an order be issued making the fee schedule submitted by the Atlantic County Medical Society be the one under which fees shall be accepted as liens in liability cases.

HOMER I. SILVERS, M.D.

The schedule of fees made by the Essex County Medical Society in accordance with the Physicians' Lien Law was filed as required by statute on October 30, 1934. It will be advertised for 30 days in the Newark Evening News; after which the required public hearing will be held Tuesday, December 11, 1934, at

10 a. m., in the Court of Common Pleas, Essex County Court House, Newark, N. J.

The hearing on the Fee Schedule in Camden County will be conducted before the Hon. Judge Wentze, in the Camden County Court House at 10 a. m. on Friday, November 23, 1934.

PSYCHIATRY FOR THE GENERAL PRACTITIONER

The pathology of physical diseases has little in common with that of diseases of the mind; and when a physician enters upon the study of psychiatry, he must learn a new system of pathology and classification which are outside of his sphere of knowledge of physical abnormalities. The treatment of psychiatric cases in their incipency usually falls upon the general practitioner; and it is therefore important that he should understand the basic principles of psychic states and be able to diagnose the broader forms of psychic states and outline a method of their treatment.

A physician attending a clinic in a hospital for mental diseases is likely to be confused as the demonstrator assumes that all the members of his class have already studied the subject from the standpoint of the specialist. What the practicing physician needs is instruction in the fundamentals of the subject. Such a course is provided by the Medical School of the University of Pennsylvania. Since it is open to fourth year medical students, physicians may be assured that the subject will be presented in a simple, practical way. The instruction is given on Tuesday evenings, at the

Institute of the Pennsylvania Hospital, 111 North 49th Street, Philadelphia, at 6:30 p. m., the classes lasting about one hour. The classes are open to physicians by special permission which may be obtained from Dr. Kenneth E. Appel, Chief of Clinic, at the Institute. Eighteen lectures are listed, but each one is a unit which may be understood without special reference to the other. The program of the course is as follows:

October 30: The Point of View of Modern Psychiatry. Etiological Factors in Nervous and Mental Disease. The Non-Specificity of Mental Disease. Dr. E. A. Strecker.

November 6: Heredity in Mental Disease. Dr. Charles W. Burr.

November 13: Neuropathology of the Psychoses. Dr. B. J. Alpers.

November 27: Psychopathology of Organic Psychoses Paresis. Dr. E. V. Eyman.

December 11: Post-encephalitic Character Changes and Behavior Problems. Dr. E. D. Bond.

December 18: Constitutional Factors in Nervous and Mental Disease with Special Reference to the Work of Kretschmer. Dr. Clifford B. Farr.

January 8: Endocrinological and Physiological Factors in Nervous and Mental Disease. The Aschner Treatment of Schizophrenia. Dr. H. D. Palmer.

January 22: Neurophysiology and Neurophysiological Concepts with Especial Reference to the Views of Pavlov, Head, Rivers, Wilson, and Kempf. Dr. Joseph Hughes.

February 5: Psychopathology of Childhood. Dr. F. H. Allen.

February 10: Psychotherapy of Childhood. Dr. F. H. Allen.

March 5: The Biology of Anxiety. Dr. J. Yaskin.

March 19 and April 2: Psychoanalysis. Dr. K. E. Appel.

April 9: The History of Psychiatric Treatment. Dr. D. H. Fuller.

April 16: The Treatment of the Psychoneuroses—Psychotherapy in General Practice. Dr. E. A. Strecker.

April 30: Clinical Psychotherapy. Dr. L. H. Smith.

May 14: Physiological and Chemical Therapy (Malaria, Typhoid Inoculation, Narcosis, Photodyn, Insulin). Dr. H. D. Palmer.

May 21: The Prognosis in Mental Disease—Follow-Up Studies. Dr. E. D. Bond.

APPEALS FOR THE PUBLIC HEALTH HOUR

The Bulletins of the County Medical Societies are carrying appeals that the physicians take a personal interest in the Public Health Hour and coöperate more heartily in the project; and are presenting strong arguments why every doctor should take part in the project. The November Bulletin of the Camden Medical Society says:

"Responding to the plea for a Public Health Hour, it has been found that a total of 57 doctors in this County were willing to coöperate. Twenty of these physicians are in the City of Camden. This number is too small to do the required work efficiently. This means that the local physicians would rather have the various public health agencies carry on immunization than do it themselves. Fifty per cent of the available doctors in the county are necessary to adequately conduct this work."

The November Bulletin of the Hudson County Medical Society says:

"It will be most unfortunate if individual physicians conduct free immunization clinics in direct competition with their colleagues in private practice.

"Each doctor is not only an individual physician; he is also a representative of *organized medicine* (County and State Medical Society). If the present form of medical practice is to continue, *organized* effort by physicians must be *proven* to be possible on a voluntary basis; otherwise the backers of State Medicine (under governmental *compulsion* and control) will have a good argument and *facts* to back it up. Your State Medical Society officers have done their part, in coöperation with the State Department of Health. The success of the 'Public Health Hour' is now up to the officers and members of the County Medical Societies."

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

NOVEMBER

6 Camden	14 Mercer
7 Hudson	14 Ocean
8 Essex	14 Burlington
8 Passaic	15 Gloucester
9 Atlantic	21 Middlesex
13 Bergen	28 Monmouth
13 Sussex	

DECEMBER

4 Camden	13 Passaic
6 Hudson	13 Somerset
11 Bergen	14 Atlantic
12 Mercer	19 Middlesex
12 Salem	20 Gloucester
12 Ocean	20 Morris
12 Union	26 Monmouth
13 Essex	

ATLANTIC COUNTY

Robert A. Kilduffe, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held Friday, October 12, 1934, in the Japanese Room at the Ambassador Hotel, Atlantic City. Dr. David B. Allman, President, welcomed the members and guests to the first fall meeting, and extended a cordial invitation to everyone to attend all the meetings. There were 83 present.

The minutes of the last regular meeting held May 11, 1934, and of a special meeting held August 10th, 1934, were read and approved.

A letter from the State Treasurer stated that the State assessment for 1935 would be \$13.00 per capita, and must be paid not later than January 26, 1935.

An invitation to the Interstate Post Graduate Medical Assembly to be held in Philadelphia, November 5th to 9th was read by the Secretary.

A letter from Mrs. E. H. Harvey enclosed a booklet of information concerning the Society for Relief of the Widows and Orphans of New Jersey physicians. Dr. Allman appointed a committee: Dr. C. L. Andrews, Chairman, Dr. D. W. Scanlon, and Dr. C. M. Fish, to obtain information as to the advisability of taking up this matter.

A letter from Dr. Ely, the State President, was read by the Secretary stating that all committee reports should be signed by all members of the committee. This procedure is especially important for the Public Health Committee and the Medical Advisory Committee. This is to be acknowledged and filed.

A letter from Dr. Nichols, Chairman of the State Public Health Committee, stated that biologicals and supplies being furnished for the "Public Health Hour" are being used in schools and institutional work. This is unfortunate in that it tends to defeat the aim of the Public Health Hour. The State Society is opposed to such practice, and sponsors the Public Health Hour plan.

Dr. J. S. Irvin, reporting for the Medical Advisory Committee, said that the E. R. A. officials felt that the bills for medical work in this County were too high; and that in order to cut down the expense, they had ruled that only emergency cases may be treated. Chronic cases may only be seen once a month.

When the E. R. A. plan to pay by cash instead of by food orders to those clients who work on E. R. A. projects was put in execution, there was a considerable number of people who immediately became too sick to work. This committee advised the appointment of certain physicians to examine these persons. Your committee did not receive the full coöperation of the County E. R. A. in this matter. We are not prepared to report fully on this incident at this time, but expect to do so at the November meeting.

Dr. W. E. Darnall reported progress for the Library Committee.

Dr. Harry Subin reported for the Entertainment Committee that the Annual Outing at Dox Folly had been a success in every way; and he thanked Drs. Mason, Uzzell and Davidson for the privilege of having the outing at their country place. He also thanked the members of the Committee for their coöperation.

Dr. Homer J. Silvers reported that the schedule of fees under the Physician's Lien Law had been filed with the County clerk.

The hearing to secure an order approving the reasonableness and sufficiency of the schedule of fees adopted by this county will be held on Monday, October 15, at 11 a. m., before the Judges of the Court of Common Pleas. It is necessary that a good representation of physicians be there at that time. (See page 652.)

Dr. Allman also urged every physician to go to the Freeholder's room in the Guarantee Trust Building for this hearing. He stated that our Assemblymen had pledged their help, and that he felt we would have ample legal assistance in this matter.

The Scientific Program was presented by Dr. William D. Haggard, F.A.C.S., D.C.L., President, American College Surgeons, Professor of Clinical Surgery, Vanderbilt University, School of Medicine, Nashville, Tennessee, who presented a paper on the delayed operation for appendicitis in delayed cases, with an analysis of 3344 operative cases. (An abstract of this paper will appear in an early issue of the Journal.—Editor's note.) The discussion was opened by Dr. Edward Klopp, Professor of Clinical Surgery, Jefferson Medical College, Philadelphia, Pa.

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held October 9 at the Hackensack Hospital with Dr. A. Liva, president in the chair. Approximately 110 members were present.

The minutes of the September meeting were read and approved.

The Executive Committee minutes were approved as printed in the Bulletin.

Dr. J. Irwin, the treasurer, reported that 236 regular members had paid their dues and that 14 were still not paid. He stated that \$13 of the membership dues were to go to the New Jersey State Medical Society next year, the same as during the past year. The due date is January 1st, and not later than January 26th. The number of delegates to the State Convention in June will depend on the number of memberships paid up by January 26th. Dr. Hallett suggested that when the bills went out on November 1st, an explanation of the above be included.

Dr. J. B. Edwards reported for the County Committee on the "Doctors' Lien Law". He stated that the committee had approved of the fee schedule submitted by the State committee on the Doctors' Lien Law, with minor additions. Dr. Edwards called attention to the fact that the fees as listed for the Doctors' Lien Law had nothing to do with the fees in private practice, and nothing to do with compensation fees. After considerable discussion Dr. Hallett moved the adoption of the fee schedule. The motion was seconded and duly passed.

Mr. Whitehead, the executive secretary, then read a letter from the Interstate Post-Graduate Medical Association of North America, inviting the doctors of Bergen County to attend the International Medical Assembly at Philadelphia on November 5 to 9 inclusive.

The following were elected to membership:

Regular—J. F. Duffy, Westwood; S. E. Robinson, Waldwick.

Junior to Regular—L. J. FitzPatrick, Ridgely Park; R. B. Hillsman, Teaneck.

Junior—G. B. Barlow, Englewood; M. M. Kroll, Cresskill; I. M. Levitas, Westwood; E. E. Wolfe, West Englewood.

Associate—G. L. Inge, Englewood.

The following applications for membership were read:

Regular—J. L. York, New Milford, and J. A. Lattina, Lodi.

Junior—J. J. Danielson, Weehawken; N. F. Myers, Glen Rock; A. R. Frederick, Rutherford, and John Calabrese, Rochelle Park.

The secretary reported that Dr. Stanley Nichols, chairman of the State Society Public Health Committee, had written that only one fifth of the doctors of the State had taken out free biologicals for immunization, and that some schools and clinics were using the free material. He urged greater effort on the part of the physicians.

The secretary asked for the names of men interested in Gastro-enterology and Proctology at the request of the State Medical Society which will have a section in these specialties at the annual meeting in June.

Dr. Levitas spoke on the proposed Mutual Aid Association of the Bergen County Medical Society and asked for a special meeting to consider it. He stated that the December meeting was open. Dr. Irwin moved that the December meeting be given to consider the formation of the Mutual Aid Association. Motion was seconded by Dr. P. Liva and passed unanimously.

The meeting was then turned over to Dr. Levitas, chairman of the Scientific Committee, who introduced Dr. E. J. Donovan, Surgeon at the Babies' Hospital and Associate Surgeon at the St. Luke's Hospital in New York City, who gave a brief talk on "Abdominal Surgery in Children".

His preliminary general remarks stressed the distinguishing characteristics of children's ready susceptibility to hemorrhage, the trauma of excessive handling and prolonged operation, and extending infection by delayed diagnosis and early interference.

He then touched on the high lights of the symptomatology of intussusception, acute appendicitis, volvulus, primary peritonitis, hypertrophic pyloric stenosis and the amenable congenital defects such as diaphragmatic hernia, and imperforate anus and esophagus. He supplemented his excellent exposition with a series of illustrative lantern slides. He closed a discussion led by Drs. Finke, Spikers, Hallett, Levitas and Ward.

A rising vote of thanks was given to Dr. Donovan for his splendid talk.

CAMDEN COUNTY

Vincent Del Duca, M.D., Reporter

The annual meeting of the *Camden County Medical Society* was held in the Camden City Dispensary Building, October 2, 1934, at 9 p. m., with the President, Dr. T. B. Lee, presiding, and 69 members present.

The following applications for membership were read for the first time: Drs.—

Henry R. Tatem, Jr., Pine Street, Audubon.

Edwin N. Murray, 601 Walnut Street, Camden.

W. A. Smith, 2 East Clinton Avenue, Oaklyn.

R. R. Betancourt, 406 Cooper Street, Camden.

Transferring from Philadelphia.

ELECTION OF OFFICERS

Dr. B. F. Buzby, Chairman of the Nominating Committee, reported the following nominations for officers and delegates:

President, F. William Shafer

Vice-President, T. K. Lewis

Secretary, Robert S. Gamon

Treasurer, E. C. Shull

Reporter, Vincent Del Duca

Historian, Helen F. Schrack

Censor, Gratton E. Day

Trustee, Alex. MacAlister

Delegates to New Jersey Medical Society to serve three years.

Beulah Hollinshead

T. B. Lee

E. G. Hummel

C. R. Hutcheson

Alternates to New Jersey Medical Society:

Stella Fisher	L. R. Wilson
George P. Meyer	A. M. McCarthy

Committee on Scientific Work:

Wesley H. Jack, Chm.	J. S. Shipman
O. R. Kline	

Delegates to Atlantic County Medical Society:

J. W. Crowley	I. E. Deibert
W. D. Evans	

Delegates to Burlington County Medical Society:

P. M. Mecray	R. K. Bush
A. H. Shafer	

Delegates to Cape May County Medical Society:

W. W. Kain	Chas. H. Jackson
E. A. Farrell	

Delegates to Cumberland County Medical Society:

A. M. K. Maldeis	G. F. West
W. F. Moore	

Delegates to Gloucester County Medical Society:

H. F. Palm	O. R. Kline
E. M. Richardson	

Delegates to Salem County Medical Society:

L. I. Glover	M. R. Hummel
Lavinia Clement	

Nominating Committee of State Society:

T. B. Lee

Nominating Committee of Camden County Medical Society:

C. R. Hutcheson, Chm.	Benj. Wroblewski
Geo. B. German	

Managers of Camden City Dispensary:

T. K. Lewis	J. E. Roberts
P. M. Mecray	J. L. Mahaffey
A. H. Lippincott	T. B. Lee
D. F. Bentley	W. W. Kain
J. E. L. Van Seiver	

These officers were unanimously elected.

Dr. E. C. Shull, historian, gave a very comprehensive survey of the past year's accomplishments of the society.

Dr. T. K. Lewis, treasurer, read his report. The Auditing Committee, appointed by the President, consisting of Drs. Mahaffey, Pratt, and Palm, reported that the books were in order and balanced correctly. On motion from the floor, the treasurer's report was accepted and ordered spread upon the minutes.

The secretary announced the purchase of an Elliott Addressograph Machine which would facilitate the issuance of the bulletin and notices of this society. He urged that the correct addresses be sent to the office of the secretary.

The secretary announced that the fee schedule of the Physicians' Lien Law was not ready to be presented to the Circuit Court Judge for approval. The State Committee has made several changes in the fee schedule which was adopted at the August meeting of this society. It also changed the preamble. These alterations in the schedule were to

have been available for discussion at this meeting, but the communication did not arrive in sufficient time for presentation. He also made note of the fact that this society would have to decide whether it wished to be represented with its own Counsel or with Counsel suggested by the State Society, when appearing before the Judge of the Circuit Court with this schedule.

The Vice-President assumed the Chair while the retiring President, T. B. Lee, read his presidential address. (See page 640.) At its conclusion he turned the gavel over to Dr. F. William Shafer, President-Elect, who assumed charge of the meeting.

SPEAKERS' BUREAU

Dr. T. K. Lewis, Chairman of the Speakers' Bureau Committee asked that he and his Committee be relieved inasmuch as he had been informed that the Woman's Auxiliary was to take over the Speakers' Bureau for the ensuing year. Discussion by Drs. Buzby and Lippincott brought out that this was not the purpose of the move to have the Woman's Auxiliary serve this committee's function. The Auxiliary was to make the contacts, and call on this Committee to furnish the speakers.

DR. RAUGHLEY'S FIFTY YEARS OF PRACTICE

The committee, consisting of Drs. MacAlister, Palm, and Osmun, to draw up appropriate resolutions honoring Dr. William C. Raughley on the completion of fifty years in the practice of medicine, presented its report.

Dr. MacAlister, Chairman, gave a biographical sketch of Dr. Raughley, and paid a glowing tribute to his faithfulness and ability in the case of his patients and the high esteem in which he was held by his fellow-practitioners. He then presented the sheepskin parchment signifying his fifty years of service. Dr. Raughley graciously accepted the award, and was given an ovation by his fellow society members.

TUBERCULIN TESTS OF SCHOOL CHILDREN

The secretary announced that the society had been approached by the Boards of Education of this county for its sanction to do tuberculin tests on the school children and high school children in this county. Dr. Pratt, chief school physician of the Camden City Schools, discussed this proposition with regard to the Grammar School Child. Dr. Mahaffey made a plea for the eradication of the tuberculous school teacher, stating that this was a greater menace than the casual child with incipient tuberculosis.

Dr. Martin Collier defined the attitude of those men doing chest work. The objective of the tuberculin test and the subsequent follow-up by the family physician with necessary x-ray studies would be to pick up the hesitant case or incipient case in the High School child, thereby saving many years in the course of treatments in this early case.

Dr. B. F. Buzby in the discussion questioned the value of tuberculin tests in older children, and also touched upon the nature of the psychological effect of such an undertaking.

Dr. H. I. Goldstein discussed the relative value of physical examinations and tuberculin tests, and decried the fact that school physicians were not permitted to expose the child to enable him to make complete chest examinations. He urged the use of annual physical examinations with check-up by the family physician.

Dr. T. K. Lewis moved that this question be referred to the Society's Public Health Committee for investigation and analysis, this Committee to report to the Society at a later date. This motion was seconded and passed unanimously.

Dr. E. G. Hummel, Chairman of the Public Health Committee, reported that he had just attended a meeting of the State Public Health Committee and this problem was being given considerable thought and careful attention throughout the state. He spoke of the magnitude of the problem and its various complications and the impossibility to arrive at a quick conclusion.

CUMBERLAND COUNTY

E. S. Corson, M.D., Bridgeton, Reporter

The regular quarterly meeting of the *Cumberland County Medical Society* was held at the Cumberland Hotel, Bridgeton, on the afternoon of October 9th, the President, Dr. Ray Simkins, presiding.

New officers were elected as follows:

President, S. D. Bennett, Millville
Vice-President, Burton Walker, Vineland
Secretary, E. C. Lyon, Bridgeton
Treasurer, H. H. Wilson, Bridgeton
Reporter, E. S. Corson, Bridgeton

Dr. Leslie E. Myatt, Chairman of the society's medical E. R. A. Committee, gave an interesting report of the vast amount of supervision that had been done, and the benefits the medical profession had derived from the E. R. A.'s assistance to the people in time of sickness.

The medical lien law, enabling hospitals and doctors to file liens against accident cases treated in hospitals, was discussed and a schedule of fees conforming to the one adopted by the State Medical Society was accepted for filing with the County Clerk.

Dr. L. A. Wilkes, Executive Secretary of the State Medical Society, discussed the use of the vaccines and toxins provided by the state, and urged the members to appoint clinic hours in which to administer them according to state regulations.

The guest speaker, Dr. E. L. Eliason, of Philadelphia, was introduced by Dr. C. Percy Lummis. His subject was "Surgical Emergencies of the Abdomen".

Rupture of the spleen and pancreas are becoming more common as automobile accidents increase in number.

The speaker said that there are three dominant questions that must be answered:

- 1st. Is it medical or surgical?
- 2nd. Operate at once or wait?
- 3rd. What is the diagnosis?

In the majority of cases, the speaker said, when in doubt, it is better to operate, for waiting has cost far more lives than operating at once.

ESSEX COUNTY

Earl Le Roy Wood, Reporter

The *Essex County Medical Society* held its 119th Annual Meeting Thursday evening, October 11, 1934, at the Academy of Medicine, Newark, with President Edward W. Sprague presiding.

The Society adopted amendments to the Constitution, Article V Sections 1 and 2, and the By-Laws, Article III Section 2, providing for the new office of Second Vice-President. The special object of the last Society meeting, that of October 2, was to consider the fee schedule for the Physicians' Lien Law and to finally act thereon. The changes then proposed and the whole schedule then completed was approved and adopted by the present meeting. The President announced the following assignments: Election tellers, Drs. E. W. Erler, Harold Murray, Paul Hosp, T. W. Harvey, Jr.; C. G. Crane, Herbert Ill and Raymond Mullin.

For the distribution of "In Memoriam", Drs. A. O. Godfrey and C. W. Barkhorn.

Auditing Committee: Drs. B. A. Furman, Francis Weber and J. W. Hurff.

Under *Report of Council*, the Secretary announced the activities of the Council since the May Society meeting, having met ten times in special sessions chiefly on the Physicians' Lien Law and its Fee Schedule.

The Society approved the suggestion of President Sprague that the Trustees of the Medical Society of New Jersey organize a Bureau on Publicity for the purpose of issuing reliable information on medical subjects, in order to controvert the misleading statements in news items and popular advertisements.

The *Treasurer* then read his annual report. On duty for 1935, he reported the action of the *Finance Committee* that the dues suggested be \$17; \$13 for the State Society, \$3 for the County Society, General Fund, and \$1 for Permanent Relief Fund. This was approved. For the Auditors, Dr. Weber reported Treasurer's books found correct as reported.

For the *Ethics Committee*, Dr. H. C. Barkhorn reported all the problems settled by personal conferences with the doctors involved; that the formulation of principles on ethical contracts laid down by Dr. Lowrey's Committee on Economics had simplified the work in this line; also that the ten principles enunciated by the A. M. A. and published in its Journal simplified the matter. Dr. Sprague remarked that grievances against doctors, which had come to him as President, had been easily settled and that they often indicated instigation from some careless remark by a doctor.

For the *Committee on Credentials*, Dr. H. Roy Van Ness reported on the meetings held prior to the Society meetings, including those of October, 1934, with the election of 45 regular and 51 associate members.

For the *Committee on Publication*, Dr. J. H. Bradshaw reported issuing ten Bulletins, November, 1933, to October, 1934, inclusive, which contained the calls for the Society meetings, the entire list of the members of the Society committees, tables of Federal and State Legislators, comparative tables of proprietary and pharmacopoeial drugs, copies of the Physicians' Lien Law, rules on Emer-

gency Relief Administration and Diphtheria Immunization, timely topics on various items of importance to members, including monthly notices on the deaths of members, "In Memoriam". He concluded by quoting—"In order that the dignity and honor of the medical profession be upheld, its standards exalted, and the advancement of medical science promoted, a physician should associate himself with Medical Societies, and contribute his time, energy, and means in order that these societies may represent the ideals of the profession."

For the newly organized *Essex County Heart Commission*, Dr. C. E. Teeter reported success in organizing the plan, which will be described in a pamphlet distributed. Monthly meetings of the Commission will be held at the Academy of Medicine with an educational program in the fundamentals of cardiology, which the members of the County Society are cordially invited to attend.

For the *Committee on Radio Broadcasting*, Dr. Alfred Stahl reported two meetings held, and four medical talks broadcasted; and for the Automobile Emblem, 33 emblems distributed to members on their subscriptions.

For the *Committee on Acute Poliomyelitis*, Dr. E. L. Smith said that it had no report.

For the *Committee on Entertainment*, Dr. A. C. Zehnder reported two testimonial dinners, one to Dr. Martland, and one to the President of the American Medical Association, Dr. Dean Lewis. They were both well attended and interesting.

For the *Committee on Control of Cancer*, Dr. H. B. Orton reported a remarkable and very successful week in December on Cancer Study and Exhibit, which was attended by 1778 citizens. There was a notably large attendance at the Society meeting at which Dr. Martland made his address. This report was accepted with a vote of thanks.

For the *Committee on the Woman's Auxiliary*, Dr. Theodore Teimer reported successful consultations with the ladies about their work, and that the members of the Auxiliary had redecorated the Committee Room of the Academy of Medicine at their own expense, and also donated \$500 to our Permanent Relief Fund.

For the *Committee on Milk*, Dr. T. W. Harvey reported for Dr. Wherry, who was absent, a satisfactory condition of the milk problem in Essex County, several dairies now delivering certified milk, that from the Woodbrook Farms being certified to by our own commission which, for this reason, is especially advocated by the members of our Society.

For the *Adjustment Board on the Compensation Law*, Dr. D. A. Kraker reported the continuance of the functions of the three representatives of the employee, the employer, and the medical profession, as originated by Dr. Eagleton, and the then Commissioner of Labor, Mr. Bryant. He suggested that now such a Board should be State-wide; and said that the harmful practice of the Commissioner's referees adjusting settlements had been stopped. He moved recognition of the advantage to the committee of the services of Dr. Jackson (representing the employers) who had now resigned. The report was received with thanks.

For the *Hospital Section of the Public Relations*

Committee, Dr. William H. Areson reported that:

1. Each municipality should care for its own indigent sick and not leave the whole burden on the physicians.

2. Hospitals should aim to be self-supporting.

3. Hospitals should collect from all patients who can pay.

4. Municipalities should pay minimum ward rate for ward cases.

5. Disapproval of County Society representation in the Hospital Council of Essex County, also of Hospital and Health Insurance.

6. Approval of (a) revocation of M.D. licenses upon unethical conduct; and (b) jail sentence for persistent illegal practice.

For the *Membership Committee*, Dr. C. F. Rathgeber reported the activity of its 22 members which resulted in the addition of 96 new members—45 regular and 51 associate. The total number of members paid up in June for the current year is such as to raise our allotment of State Society delegates one more. The total membership now paid up, three months before the end of the year, is \$41; and there are only 58 in arrears.

For the E. R. A., Dr. E. Z. Hawkes reported admirable relations between our Advisory Committee and the State Administration, the contract between the profession and the administration involving functions economical on the part of the Administration, and both economical and ethical on the part of the doctors. The delay in the State's at first paying for the service was overcome through pressure of the State Society and President Quigley, and demonstration of the successful operation of the service. The few cases of uneconomical service by our members were rectified by the appearance of those doctors before the Advisory Committee, resulting in better mutual understanding.

We must realize our moral obligation and strive to be just to all interests involved. If the expense of medical relief work is not kept within reasonable bounds, the State may abolish medical control. The members are urged to cooperate to save to themselves not only the control, but the very considerable income for the medical members.

Recent modifications of the rules are that (1) E. R. A. income to any one doctor should be limited to a maximum of \$250 a month, (2) authorizations should be cut to one call (instead of three). He urged that any questions by members should be freely made to any member of the committee, or that members attend one of the committee's weekly meetings. This report was accepted with thanks.

For the *Committee on Physicians' Lien Law*, Dr. J. I. Fort reported the success of adopting the fee schedule as published in our Bulletin. The committee plans now to have the schedule filed with the County Clerk, published for 30 days, and submitted to the Court for final acceptance.

Dr. Fort also reported for the *Committee on Illegal Practitioners*, 25 complaints received and forwarded to the State Board of Medical Examiners for disposal. It is urged that complaints of illegal practice must be accompanied by data as complete as possible in order to be handled by the State Board.

For the *General Committee on Economics*, and

Public Relations, Dr. Eagleton approved of what was being done by the doctors themselves; read from a letter by Governor Moore; and approved of the good relations between public officials and physicians. Dr. Eagleton also praised Dr. Sprague for his work as President, addressing him as follows:

"I predict for you, when you reach my age, that you will look back to this year as one of the greatest services you will have ever rendered." He closed, moving that Dr. Quigley, the President of the State Society last year, be given the floor to speak a few minutes. Dr. Quigley then paid tribute to our Society and to the President, saying:

"I wish to express my unbounded appreciation for the consistent and friendly support shown during my administration and the two or three previous years. If we had twenty other societies like Essex in this State, we would have the best State Society in the United States."

Dr. Quigley then presented Dr. Sprague with the pen given to him last April by Governor Moore after he had signed the Physicians' Lien Law with it.

For the *Committee on Economics*, Dr. Lowrey made an excellent report which included naming the hospitals which had favorably replied in taking action against case lifting.

For the *Committee on Public Health*, Dr. Edgar Ill reported excellent progress in diphtheria immunization by doctors in their private practice, urging recognition of a "Public Health Hour" for indigent patients. He added that this is a critical time, especially for the pre-school children, to prevent the government, presuming to do this practice, through boards of health and schools.

For the *Maternal Welfare Commission*, Dr. W. B. Mount reported excellent work in the survey of work done in more than a dozen hospitals, the reports being available for now seven years, some being published in the 1931 American Journal of Obstetrics and Gynecology. The funds for the expenses of the survey had come from profits in lectures under the Post-Graduate Courses under that committee. The prenatal work had thrived although the E. R. A. had caused increase in home deliveries. Maternal mortality had received intensive study which, we believe, shows commendation due to our county in contrast to statistics in other localities published by the Commonwealth Fund of New York. The action calling for consultations by a "qualified consultant" in abnormal or prolonged cases had been approved by our Society. The report was accepted with thanks.

For the *Welfare Committee*, Dr. Areson reported on the successful progress made in wholesome legislation, especially the enactment of the Physicians' Lien Law, and a State appropriation for toxoid and vaccine for doctors' use in preventive medicine.

A successful movement was made in a conference of the allied professions of medicine, dentistry, pharmacy, and nursing, representatives of the four bodies, organizing September 12, 1934, for allied action in their various mutual interests.

For the *Committee on Post-Graduate Education*, Dr. Satchwell reported six courses. The courses had been offered for \$10 for one course; \$5 for the second, and nothing for others, making \$15

for all. Total enrolment was 302 by 144 separate subscribers. The gross income from 144 subscriptions was \$1,715; and the committee paid to Rutgers University \$1,750.

For the *Committee on Necrology*, Dr. McEwen, Chairman, there was distributed the "*In Memoriam*" for 1933 containing biographical sketches on eleven members:

W. Buermann	H. Ost
J. Dennis	W. A. Wakeley
F. W. Duncker	L. Weiss
F. C. Jacobson	A. V. Wendel
I. Klein	I. D. Williams
C. McArthur	

Dr. McEwen also read the names of the ten members who had died since January 1, 1934, the members standing during the reading. The names were as follows:

R. C. Potter	A. V. Widman
C. B. Griffiths	B. N. Margulis
H. W. Thayer	H. T. Obuchowski
W. T. Hoeler	J. S. Brown
C. V. R. Bumsted	R. E. Titman

The President's address was then delivered by Dr. Sprague on "Principles of Organized Medicine". It was an admirable and thorough address on the great medical problems of the time and the ways in which our members had supported the Society measures, the standing of the profession in the eyes of the public, and the gains which had come to members of the profession as against the drift away from them into uncontrolled state medicine. (This address appears on page 634.—Editor's note.)

The following officers were elected:

President, John F. Condon, Newark
First Vice-President, A. Charles Zehnder, Newark
Second Vice-President, Edgar A. Ill, Newark
Secretary, Frank W. Pinneo, Newark
Treasurer, Robert H. Rogers, Newark
Reporter, E. LeRoy Wood, Newark

Councilors

Harry N. Comando, Newark
H. A. Schulte, Newark
Royal A. Sehaaf, Newark
H. R. Van Ness, Newark

Nominating Committee of the State Society

Alfred Stahl, Member
A. Charles Zehnder, Alternate

Delegates to the State Society

UNTIL 1937

C. C. Belling, Newark
Arthur W. Bingham, East Orange
Francis R. Carbone, Newark
John F. Condon, Newark
Hugh P. Cook, Newark
E. Zeh Hawkes, Newark
Charles L. Ill, Newark
Harrison S. Martland, Newark
August T. Mitchell, Newark
Earl H. Snively, Newark
Edward W. Sprague, Newark

Theodore Teimer, Newark
Henry J. F. Wallhauser, Newark
Elmer C. Wherry, Newark

Alternates

James S. Allen, East Orange
Mary Broadnax, Newark
E. A. Curtis, Newark
R. H. Dieffenbach, Newark
Joseph Echikson, Newark
Linn Emerson, Orange
E. A. Flynn, Belleville
Albert S. Harden, Newark
Herbert M. Ill, Newark
H. H. Kessler, Newark
S. A. Muta, West Orange
Royal A. Schaaf, Newark
Ellis Smith, Belleville
Florence Voorhees, Newark

UNTIL 1934

To fill vacancy caused by the death of C. B. Griffiths, John H. Bradshaw, Orange

DELEGATES UNTIL 1936, FOR INCREASED APPORTIONMENT

Delegate

Max Danzis, Newark

Alternate

Charles M. Robbins, Newark

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The annual social meeting of the *Gloucester County Medical Society* was held on the evening of October 18, at the Hotel Pitman, Pitman, with the physicians and their wives enjoying a splendid program that had been arranged for the occasion.

Dr. Harold Paul Sloan, Camden district superintendent of the M. E. Church, of Woodbury, was the principal speaker, delivering an inspiring and interesting address based on the life of George Washington. Dr. Ely, of Somerville, President of the New Jersey State Medical Society, and Dr. Chamberlain, of Temple University, spoke briefly.

During dinner and later the members were entertained by the Metropolitan Male Quartet, of which "Jimmy" Loughran, a favorite in this section, is the leader, and by orchestra music.

One of the features of the evening was the presentation of a "silver" medal, awarded annually to the member who has done the most for his profession and fellow man. The presentation was made by Dr. C. I. Ulmer, of Gibbstown, but the name of the recipient was not made public.

Dr. B. A. Livengood, of Swedesboro, president of the society, proved very capable as toastmaster in presiding over the fine program that was presented.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held at the Carteret Club on the evening of Tuesday, October 2, 1934, with the President, Dr. D. B. Street, in the chair.

The annual reports of the several committees

were presented after having been published in the Bulletin of October.

The Committee on Constitution and By-Laws suggested a number of amendments which were adopted.

REPORT OF COMMITTEE ON PHYSICIANS' LIEN LAW

Dr. Pyle in presenting some additions to the Physicians' Lien Law which had been overlooked, stated that the President, Dr. Street, had appointed a committee of over forty men who had met a week ago and had a very lively discussion for several hours, concerning the fees embodied in this law. These fees are to be brought before the Common Pleas Court to be used as reference in deciding the reasonableness of a medical man's fee when he puts in his lien for a liability case. The committee decided to recommend that the society accept these fees as published in the bulletin as amended here at this meeting.

NEW MEMBERS

Dr. Louis D'Elia was elected to membership.

The following new applicants for membership were presented:

Frederick W. Dersheimer, 546 Bergen Ave., J. City
Marcus E. Carpenter, 114 Storms Ave., Jersey City
Charles Andrew Landshof, 50 Glenwod Ave., J. City
James Henry Gillen, 283 Fourth St., Jersey City
Daniel Salvatore Cieri, 315 Central Ave. Union City
Joseph David Goldstein, 3263 Boulevard, Jersey City
Peter J. Bonanno, 518 35th St., North Bergen
Sidney L. Siegel, 29 Bentley Ave., Jersey City
M. Leonard Kimmel, 142 Manhattan Ave., J. City
Edwin J. G. Valentine, Jr., 559 Summit Ave., J. City
John Coughlin, 43 Arlington Ave., Jersey City
Allan Klein, 5580 Boulevard, North Bergen

NEW OFFICERS

Officers for the coming year were elected as follows:

President, Ellis J. Chapman
Vice-President, Traugott J. Schuck
Treasurer, Charles B. Kelley
Secretary, Thomas McG. Brennock
Reporter, John N. Connell

Trustees (three years to 1937)

George F. Sullivan A. J. Conty

Censor (three years to 1937)

A. E. Jaffin

Audit Committee (three years to 1937)

M. J. Weiss

Publication Committee (three years to 1937)

S. R. Woodruff W. T. Callery
S. C. Braunstein S. A. Cosgrove

Members State Nominating Committee (one year)

Joseph F. Londrigan F. J. McLoughlin, Alt.

Committee on Constitution and By-Laws

A. P. Hasking

Legislative Committee (three years to 1937)

B. S. Pollak A. E. Kuhlmann
Jos. F. Londrigan

Public Health Committee (three years to 1937)

C. P. DeFuccio Earl Halligan
A. E. Jaffin

Delegates to the State Society (three years to 1937)

	Alternates
A. P. Hasking	L. K. Perkel
Henry Klaus	G. Ginsberg
Jos. F. Londrigan	V. J. Sheeran
George B. Spath	S. B. Barishaw
W. A. Pinkerton	H. G. Comora
G. S. Kerdasha	E. J. Daly
F. J. McLoughlin	P. A. Simeone
D. B. Street	Earl Halligan

Election Committee to be Elected in October, 1934 (to serve in 1935)

William Eckert	S. G. Scott
Walter Hammer	D. D. Dougherty
H. J. Perlberg	Wm. Doody

Nominating Committee (for the year 1935)

John B. Faison	J. Lawrence Evans
Thomas J. White	E. M. Kiely
Charles J. Larkey	

APPOINTMENT OF COMMITTEES

The new President, Dr. Ellis J. Chapman, was inducted into office by his predecessor, Dr. D. B. Street. Dr. Chapman made the following appointments to the Committees of the Society:

Welfare Committee (three years to 1937)

J. Lawrence Evans, Chairman
E. J. Luippold W. L. Williamson

Scientific Committee

B. S. Pollak, Chairman
W. W. Maver Alvin E. Kuhlmann

Membership Committee

E. A. P. Peters, Chairman
R. M. Bitten Otto Mustermann
Louis W. Dodson J. J. Pagliughi
Oscar Jacks J. S. Madaras
Joseph Koppel Frank Pearlstein
Miles T. Long Walter Weber
J. S. McDede Philip Kresch
Edward A. Murphy Frank Spano
A. R. Rieman Frank P. Nicholson
Reever L. Ballinger Max Miller
H. J. Schwarz

Publicity Committee (three year period)

Thomas A. Higgins, Chairman

Post Graduate Committee (three year period),

H. F. Tidwell John B. Faison
Harold Benjamin H. Rowland Furlonge
James L. Cobham

SCIENTIFIC SESSION

The speaker of the evening was Dr. S. Bernard Wortis, Assistant Professor of Neurology, New York University and Bellevue Medical School, whose subject was "Head Injuries".

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The *Mercer County Medical Society* met at the Trenton Country Club on the evening of October 10th, President Connelly presiding. The minutes of the preceding meeting were read and approved.

A moving picture, entitled "Science and Art of Obstetrics Showing Normal Labor and Emergency Operations" preceded the business session.

Dr. North, treasurer, made a verbal report; and following a statement relative to the disposition of funds of the society, expressed the desire for the appointment of a Finance Committee. The responsibility he felt was of such a nature that he wished advice, rather than assume entire responsibility alone in the matter.

A communication from Dr. Charles H. Mitchell, relative to the system governing E. R. A. work, as sponsored by the society, was read.

The letter not only contained a severe protest against the prevailing ruling, relative to salaried physicians being deprived from participating in E. R. A. work, but also a vigorous condemnation of the society as a whole in its apparent approval and support of such an unfair practice.

Following a most spirited discussion of the contents of this communication, the society moved to go on record as in favor "of any physician in general practice, licensed to practice medicine in the County of Mercer, excepting those holding a Municipal, County or State full-time position, being eligible for E. R. A. work."

The secretary read a communication from William B. Meytrott, Mercer County Supervisor of Medication, containing a resume of the Emergency Relief Medical situation, with expressions of gratitude for the generous sacrifice of time given by the Advisory Committee.

A communication from the Executive Secretary citing certain flagrant violations of the E. R. A. agreement, with the information that the Advisory Committee will be furnished with the necessary outline governing the obligations and powers invested in said committee. The violations to which reference was made, were in no way connected with the conduct of the E. R. A. in Mercer County.

An earnest appeal for a more thorough support of the "Fight on Diphtheria" through "The Public Health Hour", with diagrammatic percentages on Whooping Cough, Scarlet Fever, Measles, Diphtheria and others was read and discussed.

Dr. Stanley Nichols, Chairman of the State Public Health Committee sent a communication in which he vigorously emphasized the necessity of closer coöperation and a more intensive application of organization in the conduct of this campaign.

President Ely called the attention of all committees in submitting reports, that such reports must be signed by each member, thus sharing responsibility.

A very interesting and enlightening communication from Dr. Wilbur Watts, Chairman of the Advisory Committee on E. R. A. was read. This report, in the nature of a resume of the work so far accomplished since the inception of medical relief,

was concise and self-explanatory, and revealed the many complex and perplexing problems confronting the medical profession in the endeavor to provide adequate care medically and surgically for those dependent upon this form of relief.

A communication relative to the conduct of the Crippled Children's Commission of New Jersey, regarding infantile paralysis was read.

Following thorough discussion of the "*Fee Schedule*", a discussion, the report as presented by the committee of which Dr. Elmer P. Weigel is Chairman was adopted with such introductory paragraphs as were recently added by that committee.

Acknowledgements were read from the families of deceased Doctors Clark, Douress, Franklin, and Van Neste to whom memorials had been sent.

Dr. Frank A. Nonziato was regularly elected to Associate membership.

Applications for Active Membership were read and referred to committee as follows: Drs. N. H. D'Gianni, J. J. Belfer, J. B. Spradley, J. A. Tempesto, H. S. Urbaniak, L. A. Wilkes.

Applications for Associate membership were read and referred to committee as follows:

Drs. T. E. Camper, Sydney G. Fine, A. E. Franzoni, Alexander Klein, Paul Klemptner, Edward Kuch, C. B. Matthews, S. R. Miller, S. E. Seidelman, F. S. Storaci, Edward L. Waldron, A. A. Wilner, W. F. J. Wittenborn, A. E. Ogden, H. W. Swertfeger.

The usual committee, composed of the members of the Program Committee and the treasurer, was empowered to arrange for the Annual Banquet.

MIDDLESEX COUNTY

George Hilker, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held at Pfaff's Restaurant, Metuchen, New Jersey, on Wednesday, October 17th, 1934, with approximately sixty members present.

The minutes of the previous meeting were read and approved.

The following were admitted to associate membership in the Society:

Dr. John J. Jablonski, South River.
Dr. Anthony J. Pellicane, New Brunswick.
Dr. Price T. Watson, Milltown.
Dr. Henry A. Belafsky, Woodbridge.
Dr. G. W. Pascall, Jr., Milltown.

Following the reading of a communication from the State Committee on the Doctors' Lien Law, the County Society unanimously approved the fee schedule sent for consideration. These fees shall in no way influence the charges any physician may make in his private practice. The fees stated are maximum fees, and the charges made for each service shall be up to the amount stated.

Dr. Wilentz, reporting for the Arbitration Committee of the E. R. A., called the doctors' attention to the following rules:

1. E. R. A. patients are not to go to specialists, unless referred by the general practitioner.
2. Complications of Neisserian or luetic infections will not be compensable by the E. R. A.

3. All chronic cases should be referred to the City Physicians.

4. Doctors in rural communities only are to be paid fifty cents for each prescription dispensed by them.

The Arbitration Committee of the E. R. A. then set forth a new plan of operation to be suggested to the County and State Emergency Relief Administration. The plan in outline form consists in:

1. All E. R. A. patients shall go to their family physician without first getting an authorization blank.

2. The attending doctor is shown the relief card which identifies the case as one on relief.

3. The doctor decides if the case should be treated as an E. R. A. case—if so, he contacts a doctor chosen by the Society as a "referee" and after an explanation the "referee" doctor passes on the "attending's" request for payment and authorizes the number of visits to be given.

It is claimed that this plan will take the medical decisions out of the domain of lay workers and return them to the doctors where they properly belong. (See page 649.)

After some discussion, the plan was approved in principle by the Society. However, the detailed working of such a plan would have to be decided later between the E. R. A. and the medical profession. It was felt that the plan may prove thought-provoking so that a better form of administration of medical relief might take place in the future.

The speaker of the evening, Dr. A. M. Ornstein, Assistant Professor of Neurology at the University of Pennsylvania, was then presented. Dr. Ornstein gave an illustrated lecture on "Medico-Legal Problems, Hysterical State and Post-Encephalitic Disorders."

Excellent moving pictures were shown of the various types of cases which Dr. Ornstein described and explained. A stimulating discussion took place, after which the meeting adjourned.

PASSAIC COUNTY

Sigurd W. Johnsen, M.D., Reporter

The annual meeting of the *Passaic County Medical Association* was held with the Passaic Practitioners Club at the Ritz Ballroom, Passaic, October 11, 1934, at 9 p. m. Dr. H. F. Willard presided as President.

A motion was carried to take applications for associate memberships until the Committee on By-Laws had formulated a definite policy regarding the privileges, obligations, and dues for such memberships.

The applications of Dr. Michael Raab, and Dr. Abraham Reinhorn, having been passed favorably by the Board of Censors, were voted upon, and they were duly elected to membership.

Dr. A. S. Blumgarten, New York City, then read a very interesting paper on "Endocrinology for the General Practitioner". A most excellent presentation of the entire field of endocrinology was given by Dr. Blumgarten, in which the newer aspects of therapy and knowledge were clearly and specifically

demonstrated. The lecture was followed by an interesting lantern slide demonstration.

Discussion of the paper was brief due to the lack of time, but appreciation to Dr. Blumgarten for his excellent paper was expressed.

The report of the nominating committee was then submitted, and the following officers duly elected:

President, Dr. Wright MacMillan
First Vice-President, Dr. Norman Dingman
Second Vice-President, Dr. Fred Vosburgh
Secretary, Dr. Wayne Hall
Treasurer, Dr. Edward F. Leonhard
Reporter, Dr. Sigurd W. Johnsen

The meeting was then adjourned and the members assembled at the tables for collation.

SALEM COUNTY

William H. James, M.D., Reporter

The annual meeting of the *Salem County Medical Society* was held October 10th, 1934, at the Memorial Hospital in Salem, with the President, Dr. W. T. Hilliard, presiding.

The society voted to adopt the new schedule of fees recommended by the Committee on the Physicians' Lien Law of the State Medical Society.

It was also voted that the committee accept the services of an attorney offered by the State Medical Society, to appear, on the presentation of the fee schedule, before the local Judge.

There were a number of other matters that came up for discussion, but they were so complicated by "red tape" that the members thought it advisable to take no action.

This being the annual meeting, the following officers were elected:

President, Frank L. Perry
Vice-President, C. L. Fleming
Secretary and Treasurer, David W. Green
Reporter, William H. James.

Nominating Committee for State Society:

David W. Green Alternate John S. Dunn
Delegate to State Society:

David W. Green Alternate L. C. Hummel

Censors:

Frank L. Perry William H. James
L. C. Hummel

At the conclusion of the meeting we were invited to the dining room in the Hospital to enjoy a splendid luncheon prepared by Mrs. Davis, the Superintendent of Nurses.

SOMERSET COUNTY

J. L. Young, M.D., Reporter

The regular monthly meeting, and the 118th Annual Meeting of the Somerset County Medical Society, was held at the Blue Hills Plantation Inn near Dunellen, N. J., on October 11, 1934. The meeting was called to order by the Acting President, Dr. Hegeman, at about 12:30 p. m., and with the following 28 members present: Drs. Anderson, Albrecht, Barbour, Benjamin Borow, L. Borow, Henry Borow, Cooper, Cook, Dunden, Earp, Ely, Field, Flint, Francis, Hegeman, Hird, Hamblin, Knight, Lawton, Levy, Lovejoy, Melgh, Pogoloff, Panigrossi, Renner, Sferra, Smalley and B. Wallach.

Guests present were Senator Dryden Kuser; John M. Fasoli, Director of the E. R. A. of Somerset County; and Dr. LeRoy A. Wilkes, Executive Secretary of the Medical Society of New Jersey.

The Board of Censors reported favorably on four new applicants, Drs. H. O. Hamblin, Banks S. Baker, Elmer J. Lukats and Dr. Scott. These men were then elected to the society.

Dr. Flint, Chairman Protetempore of the Public Health Committee, rendered a report of the work done thus far by that committee. As to the application of the Mantoux test, the Tuberculosis League and the chairman of this committee agree that the test should be performed in Somerset County. The details of this program will be worked out and reported at a later meeting.

As to the diphtheria immunization program sponsored by the State Board of Health in coöperation with the Medical Society, this committee has made much progress. All physicians have been approached and those who have agreed to the Public Health Hour have stated their hours for doing this work. The month of November appears to be sufficient for the completion of this undertaking.

Dr. Barbour, representing the Fee Schedule for the Doctors' Lien Law, reported that the committee was in agreement with the schedule laid down by the State committee. This committee was instructed to file this schedule with the County Clerk as prescribed by law.

The Post-Graduate Committee, represented by Dr. Renner, and the County Welfare Committee, represented by Dr. Field, rendered short reports.

An application for membership was received from Dr. John Gordon Ross, of Basking Ridge.

Dr. Stillwell, Chairman of the Nominating Committee, presented the following names for officers for the coming year:

President: Dr. R. F. Hegeman.
Vice-President: Dr. W. B. Gray.
Secretary: Dr. A. F. W. Sferra.
Treasurer: Dr. A. A. Lawton.
Reporter: Dr. J. L. Young.

Delegate to the State Convention for the years 1935-36-37: Dr. D. S. Renner.

Alternate for 1934-35-36: Dr. J. H. Cooper.

Member of Nominating Committee at the State Convention 1935: Dr. D. S. Renner.

The Society approved the above names, and elected these nominees to office.

There was no new business and the meeting was adjourned. The Auxilliary joined the Society at dinner, after which the Society heard addresses by Honorable Dryden Kuser, John M. Fasoli, Dr. Ely and Dr. LeRoy A. Wilkes. Mr. Kuser, State Senator from Somerset County, spoke on five legislative matters of interest to the doctors. Mr. Fasoli, Director of E. R. A. in Somerset County, spoke on matters pertaining to E. R. A. and the physician.

Dr. Ely, the President of the Medical Society of New Jersey and a fellow member of the Somerset County Medical Society, spoke on the aims and aspirations of the State Society and the importance of coöperation of all the members in putting over its program. Dr. LeRoy A. Wilkes, Executive Secretary of the Medical Society of New Jersey, spoke on "The Medical Society of New Jersey Organizes to Provide Community Health Services".

UNION COUNTY

Russell A. Shirrefs, M.D., Reporter

The annual meeting of the *Union County Medical Society* was held at the Elizabeth General Hospital on the evening of October 10th. There was the largest attendance on record, interest in the meeting being stimulated by the election of officers, and the unusual fact of there being two competing tickets.

The retiring president, Dr. Watson B. Morris of Springfield, was the speaker of the evening, reviewing the work accomplished during the year and reading a paper entitled, "The Future of Medical Practice". (See page 642.)

The following physicians were elected to membership:

Cyril M. Canright, Cranford
Carleton B. Orton, Roselle
George M. Walters, Westfield
Frederick B. Western, Union
Leon C. Dwoyer, Linden
H. C. Stillweil, Rahway
George F. Hilker, Perth Amboy
Thomas J. Minnella, Summit
Maurice M. Davidson, Elizabeth

There were also 17 proposals for membership to be acted on at the next meeting.

A letter was ordered sent to Governor Moore, commending him for his support of various programs presented by the medical men of the state.

The election was closely contested, counting of the ballots continuing until after 1 a. m., and some of the candidates winning by the narrow margin of two votes. Those elected were:

President, Edmund S. Krans, Plainfield
Vice-President, Thomas J. Walsh, Elizabeth
Secretary, Lorimer B. Armstrong, Westfield
Treasurer, Alden R. Hoover, Elizabeth
Reporter, Russell A. Shirrefs, Elizabeth
Censor, Charles H. Schlichter, Elizabeth
Board of Trustees:

J. B. Harrison, Westfield
Public Health and Relations Committee:
Norman W. Burritt, Summit
State Nominating Committee:

Stephen T. Quinn, Elizabeth
Committee on Scientific and Literary Work:
E. W. Lance, Rahway
Joseph T. Labow, Elizabeth
Frederick Lathrop, Plainfield

Annual Delegates	Alternate Delegates
E. W. Lance, Rahway	A. J. Drury, Roselle
R. J. Walsh, Roselle	N. W. Currie, Plainfield
M. L. Ripps, Elizabeth	Harold Johnson, Plainfield
C. A. Brokaw, Elizabeth	Walter Phelan, Elizabeth
H. E. Abel, Elizabeth	E. J. Carlin, Roselle
J. G. Boyes, Plainfield	W. J. Hallock, Berkeley Hgs.

The Treasurer's Report was read, showing a comfortable balance in the treasury, and a membership of 256. It was decided that dues for the year should not exceed \$13.00.

Westfield Medical Society

Frederick A. Kinch, M.D., Reporter

The October and Annual Meeting of the *Westfield Medical Society* met on October 9 in the Y. M.

C. A. building. The society is a local organization of the physicians of Westfield and its vicinity. It was formed on June 6, 1906, and has fourteen members. It has met in the homes of the physicians, but the influx of new and younger members made the society so large that it was inconvenient and burdensome for a member to entertain at his home as formerly.

The following officers were elected for the ensuing year: President, Fiske Wood; Vice-President, E. Milton Staub; Secretary-Treasurer, L. R. Herrington; Comptroller, Charles T. Decker.

The members reported a number of interesting cases, after which a social hour was spent getting acquainted with the new medical men and women. The attendance numbered twenty-three members and guests.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The annual meeting of the *Warren County Medical Society* was held in the Hotel Belvidere, Belvidere, N. J., Tuesday, October 16, 1934, with the President, Dr. Emery Krausz, presiding.

The following members were present: Drs. H. Baldauf, L. Bloom, H. Bossard, G. Cummings, F. Curtis, F. Gordon, L. Hackett, D. Jackson, E. Krausz, C. Lyons, F. Shimer, W. Skinner, W. Varney, J. Weres and A. Zuck, fifteen in number.

Visitors present: Dr. Lancelot Ely, President of The Medical Society of New Jersey; Dr. C. C. Beling, Councilor of the First District; Dr. H. F. Hoffman, of the Allentown State Hospital, Allentown, Pa.; Dr. E. Lane, of Blommsbury, N. J.; Dr. J. Lemmon, of Washington, N. J.; and Dr. C. Smith, of Oxford, N. J.

Dr. Hoffman read a very interesting paper on "The Mechanism of the Brain", which was discussed by Drs. Krausz, Bloom, Beling, and Gordon.

Dr. Ely, our State President, spoke about the benefits of the State Society to the individual doctor through its insurance. He urged each doctor to read The Journal in order to familiarize himself with the workings of the State Society. Dr. Morrison spoke briefly on the benefits of membership in the County and State Medical Societies. Dr. Beling spoke briefly on the necessity of insurance.

Dr. J. M. Smith, of Hackettstown, was elected to membership.

The President then appointed a Nominating Committee consisting of Drs. H. B. Bossard, L. Bloom and A. Zuck.

Election of officers for the ensuing year resulted in the unanimous selection of the recommendations of the Nominating Committee as follows:

President, Dr. Herman Baldauf, Belvidere.
Vice-President, Dr. William Varney, Washington.
Secretary, Dr. William Skinner, Washington.
Treasurer, Dr. C. W. Cummings, Belvidere.
Reporter, Dr. H. B. Bossard, Phillipsburg, R. D. No. 2.

Delegate to the State Society, 3 years, Dr. L. W. Hackett, Washington.

Annual Delegate, Dr. Emery Krausz, Phillipsburg.
Alternate, Dr. H. Baldauf, Belvidere.

OBITUARIES

FRIEND BENNETT GILPIN, M.D.

The Clinical Society of The Elizabeth General Hospital and Dispensary records, with sorrow, the passing of one who has been a member of this Society for many years, Friend Bennett Gilpin, M.D., who died on October 2, 1934.

Dr. Gilpin was an outstanding practitioner of medicine. He possessed the virtues of the ideal medical man. He was patriotic, enlisting for service in the Spanish-American War in the Medical Detachment of a regiment of his native State of Pennsylvania while he was a medical student. The same spirit moved him in the World War when he was with the first group of doctors called from New Jersey.

He began the practice of medicine as a country doctor, following in the footsteps of his father, whose high principles he felt he could best carry out in a rural area. He came to Cranford in 1905, where he exhibited the kindliness, the deep personal interest, the responsibility and the sympathetic feeling of the real doctor for his patients. The response of the community to those high characteristics is shown today by the many who mourn his passing. The memory of these tributes will prove a beautiful heritage to his family.

His service to the Elizabeth General Hospital and Dispensary, beginning as an interne and culminating as Chief of the Ear, Nose and Throat Clinic, was always of the highest order. He persistently declined promotion to the Attending Staff.

Upright and just, his was a character devoid of rancor, malice, jealousy, or envy.

We, the members of this Society, are proud to record these sentiments and direct them to be made part of the records, so that those doctors that come after us may read, and be guided, and be in-

spired by the exemplary professional life of our colleague, Friend Bennett Gilpin. To his family, we extend our deepest sympathy, at the same time sharing with them the pride in the life of this outstanding doctor.

Charles H. Schlichter, M.D.,

Milton A. Shangle, M.D.,

George W. Strickland, M.D.,
Committee.

DR. FLORA ADAMS

Dr. Flora Adams, a practicing physician, of Hackensack, and her mother, Mrs. Charles F. Adams, were killed on October 19 in an automobile accident in Hackensack. Dr. Adams was the daughter of Dr. Charles F. Adams, who practiced medicine in Hackensack for many years until his death in 1924.

Dr. Flora Adams graduated from Wellesley College in 1915 and received her degree of M.D. from Cornell in 1920. She served an internship in the Worcester Memorial Hospital and commenced the practice of medicine in partnership with her father, specializing in gynecology.

GEOFFREY O. TUNISON, M.D.

Dr. Geoffrey Orlando Tunison, a practitioner of medicine in Oxford, Warren County, for nearly fifty years and an honored member of the Warren County Medical Society, died in his home after an illness of three months. He was a native of Hunterdon County, but had lived in Oxford since he was ten years of age.

Dr. Tunison taught school in Hunterdon County for four years, and later studied medicine in Jefferson Medical College. He has practiced medicine in Oxford since his graduation in 1885.

LIST OF PHYSICIANS DYING IN NEW JERSEY DURING SEPTEMBER, 1934

NAME	PLACE OF DEATH	RESIDENCE	DATE OF DEATH
Francisco H. Busquet	Manasquan	Havana, Cuba	September 8
Wesley J. Barrett	Haddonfield (Camden Co.)	Haddonfield	September 13
Frank Cuireczak	Elizabeth	Elizabeth	September 16
George S. Dudley	New Brunswick	New Brunswick	September 16
Simon Horowitz	East Orange	East Orange	September 6
Henry J. Strauch	Manasquan	Donora, Pa.	September 8
Edward B. Terry	Absecon	Absecon	September 29
Russell Titman	Glen Ridge	East Orange	September 8
William Van Gleson	Glen Ridge	Bloomfield	September 7

THE WOMAN'S AUXILIARY

EXECUTIVE BOARD MEETING

October 8, 1934

By Mrs. Marcus Newcomb, Recording Secretary

A meeting of the Executive Board of the Woman's Auxiliary to the Medical Society of New Jersey was held in the Walt Whitman Hotel, Camden, on October 8, 1934.

The meeting was called to order at 11:20 a. m., with the new President, Mrs. A. J. Casselman, presiding. She opened the meeting with a few words of welcome and of appreciation of the large number who were present. She said that she would not take the time for a roll call, as those who were attending the meeting had registered, 37 in all.

Minutes: The minutes of the last meeting, held in Atlantic City June 6, 1934, were read and approved after the correction of a name.

Treasurer's Report: The Treasurer's report was read, and showed a balance in the General Fund of \$114.89 and in the Annual Meeting Fund of \$244.72. Total, \$359.61. The report in detail is filed with the minutes. It was moved by Mrs. John Nevin and seconded by Mrs. Theodore Teimer that the Treasurer's report be accepted. Motion carried.

Bills: The President asked for presentation of bills for payment. None was presented.

Correspondence: The Corresponding Secretary, Mrs. O. R. Carlander, read letters from three members of the Executive Board, Mrs. Margaret L. Stone, Mrs. Harriet D. Russell and Mrs. L. H. Campbell, President of Monmouth County Auxiliary, regretting their inability to attend the Board meeting.

A communication from the Federation of Women's Clubs was read regarding the Yardley Memorial Fund. A motion was made by Mrs. Hunter and seconded by Mrs. Renner that \$5.00 be given to this fund. Carried.

The resignation of Mrs. Paulina A. North as Chairman of Publicity was read. A motion was made by Mrs. Nevin and seconded by Mrs. Clarke that the resignation be accepted. Carried. The President then appointed Mrs. G. S. Laird, of Westfield, to fill the vacancy.

A letter was read from Mrs. Robert W. Tomlinson concerning the A. M. A. and Canadian Medical Association meeting to be held in Atlantic City next summer. Early planning was urged.

Printed Materials: The President announced that pamphlets containing reports of the transactions of the Woman's Auxiliary at the annual meeting in Atlantic City last June were ready to give out. Copies of the Primer, form letters for prospective members and Hand Books at 40 cents a copy were also on the table for those who wanted them.

Mrs. Lippincott called the Board's attention to the new Study Envelopes which were ready—one on milk and one on the prevention of blindness.

Guest Speakers: The President introduced Dr. Frank Overton, Editor of the State Journal. He stressed the fact that the Woman's Auxiliary has no definite objective. He thought that the Auxiliary should be the connecting link between lay

organizations and the medical profession. The County Medical Society acts as adviser of the community on health problems and the individual doctor advises the sick person; but the profession is not reaching the well persons. Public Health and Tuberculosis organizations are working for community health. The State and County Medical Societies wish to tie up with lay organizations. All lay organizations are anxious to have health talks, and the Medical Societies are ready to organize for speakers. The Parent-Teacher Association is the lay organization presenting the greatest possibilities for spreading health information. He referred to the A. M. A. meeting next June and said that as hostesses, we should have our programs ready soon. He said that he was preparing lantern slides for the use of speakers, so that material could be presented through the eye as well as through the ear.

The President stated that our Advisory Board from the State Medical Society consisted of Dr. D. S. Renner, of Skillman, Chairman; Dr. E. W. Sprague, of Newark, and Dr. W. K. Campbell, of Long Branch. She then introduced Dr. Renner.

Dr. Renner said that he wants us to feel free to call on him whenever we wanted to know anything, and he would find the answer for us. He thought it much better to keep out of a hole than to be dug out after getting into the hole.

Dr. Lancelot Ely, President of the State Medical Society, was introduced as a strong ally of the Woman's Auxiliary. Dr. Ely said that Somerset County was one of the early groups to organize, and that he had been a close follower of their Auxiliary. It meets the same night as the County Medical Society, and the members are occasionally invited to hear papers or see moving pictures presented before the Medical Society. He said that the Advisory Committee did not function last year, and that he had selected Dr. Renner, Dr. Sprague and Dr. Campbell because they were really interested in the Auxiliary.

Dr. Ely then spoke about getting information across to lay organizations and mentioned the P.-T. A. as the greatest group. He told us first to get our groups, and then the speakers. He said that Dr. Stanley H. Nichols was very active as Chairman of the Public Health Committee and ready to coöperate with us. He told how the problems had changed during the last twenty-five years. The control of typhoid, scarlet fever, diphtheria, and other epidemic diseases had lessened the work of the family physician. Better hospitalization and clinics have also taken much work away. He said we must try to revert the public mind back to the physicians and get them to do the work instead of the clinics. He stated that the Public Health Committee is advocating pre-school examination of children by the family physician. The child should go to the doctor's office every six months, be in-

noculated for preventable diseases, and have a complete record to take when he goes to school.

He then took up the question of the Society for the Relief of Widows and Orphans. He said the last annual report showed that there are 2,891 members of the State Society, and that only 532 belong to the Widows and Orphans Society. He stated that the object of the society was to provide immediate cash for the family when the doctor died. He next spoke of the Home for Worn-Out Physicians which is sponsored by the Hudson County Auxiliary, saying he considered it one of the best projects that could be attempted.

Dr. Ely advised that, whenever possible, we should try to be active members of different lay organizations where health programs arise, and through which we would be in better position to help check false ideas given out through the radio and advertising agencies. He urged us to try to get more counties to organize, and said that, of the twenty-one counties only fourteen are organized. He closed by saying that the Board of Trustees is back of our work and that, through the executive office, we could obtain outlines of talks telling us what to say and what not to say.

President Casselman asked for questions or comments.

Mrs. North asked whether the County Societies knew that the State Society was back of the Widows and Orphans Fund. Dr. Ely answered that Essex County started the fund, and that, although the State Society approved of it, it was not a part of the State Society.

Mrs. Lippincott said that, if this fund had the approval of the State Society, the County Societies should be told of it.

Mrs. Teimer, Chairman of the Widows and Orphans Fund Committee, said that she had had no coöperation in her work. She had asked each County President to appoint a Chairman, but so far many counties had none. She stated that forty-two men had been dropped last year; that the cost last year was \$14.00 per member, that only 516 doctors in the State belonged now; that, if a physician thought that his wife would not need the \$500.00 at his death, he ought to be willing to do this for others who might need the help. She said she planned to keep up the same program this year and would like suggestions as to how to reach the men.

Mrs. Teimer suggested that the critics come to the meetings and see what they are doing. She stated that the assessments during the last six months amounted to \$6.00. She said that this had been Dr. Ill's hobby for fifty years.

The President said that Mrs. Hubbard's point of view was quite universal, and that many physicians had the same idea.

Mrs. Lippincott said that each woman had influence with her own husband, and that she had got hers to join. Mrs. Casselman rejoined that she had not.

Dr. Ely said that he had joined thirty years ago to help some doctor; that every three months one doctor joining with 500 others is going to put into the hands of some widow \$500.00 to help tide her over; that the law often comes in and wives have

to get a friend to advance money; there are often sad situations because widows are not able to get hold of money for immediate use.

Mrs. Teimer replied that that was not the idea.

The President then referred to the matter of the Convalescent Home and said Hudson County was asked to present their plan to the Advisory Board. She said that the Auxiliary was fairly well organized as to doctors' wives being members of lay organizations.

Mrs. Nicholson, of Hudson County, said she had just come home but that she would soon have information on the Convalescent Home to present to the Medical Society.

Reverting to the Widows and Orphans Fund, Mrs. Pechin asked whether the Auxiliary could not give an assessment at each death. Mrs. Nevin replied that they were not in need of funds, that there was \$52,000 in the sinking fund.

Mrs. Lippincott explained that each membership increased the amount.

Dr. Renner said that the proposed donation from the Auxiliary would conflict with the By-Laws and that the Sinking Fund is an accumulation, the income from which is used in special cases where the need of relief is great, such as helping a widow care for her children.

Mrs. Teimer said that, according to the By-Laws, any member of the State Medical Society is eligible to join.

Mrs. Renner said that Dr. Ill spoke for them in Somerset County and suggested that other counties get him to speak.

Dr. Renner replied that Dr. Ill had circularized every member of the Society, but that probably most of these circulars found their way into the waste basket.

Mrs. Teimer said that she had sent information pamphlets to the various counties.

Mrs. Casselman recommended that Mrs. Teimer go to the counties in behalf of the Widows and Orphans Fund.

Mrs. Nicholson asked that the Convalescent Home be kept in mind, with the idea of obtaining a good site.

Reports of Committee Chairmen: The President then asked for reports from the Committee Chairmen. She first called on Mrs. Don Epler, Chairman of *Public Health Committee*. She read an outline to be followed by the various Auxiliaries. A copy is attached to this report. On motion, the Board accepted the program outlined.

Mrs. A. Haines Lippincott, *Chairman of Public Relations*, said she considered this the most important work of the Auxiliary. She then read excerpts from the National Committee Report, laying particular emphasis on the Summer Round-Up program conducted by Parent-Teacher Associations, and urging that the family physician make the annual examination. A copy of these recommendations is attached.

Mrs. G. E. McDonnell, President of Burlington County Auxiliary and prominent in P.-T. A. work, suggested that we had better get after the Public Nursing Committee if we want to get the matter straightened out. She said that every P.-T. A. is working for credits.

Mrs. Casselman asked her how many defects were taken care of after they were found out. Mrs. McDonnell replied that 54 were corrected out of 56 in the group in which she is interested. Mrs. Casselman said she had talked with a physician in Camden County and he said that the Summer Round-Up was not worth the trouble.

At this point, the meeting was adjourned for luncheon.

Before leaving the tables, the Board was shown the lantern slides by Dr. Overton to demonstrate how talks might be aided by the use of pictures, etc.

The meeting was then resumed and the President called on Mrs. G. S. Laird, Chairman of *Publicity and Reports*. Mrs. Laird said she planned to write the various Auxiliaries to ask for reports, and that all matters for the Journal must be sent to Dr. Overton by the 20th of each month and not later than the 7th of the month. She suggested that scrap books be kept in which clippings from the press and other interesting items be put, the finished product to be exhibited at the meeting of the National Organization in June.

The *Historian*, Mrs. James Hunter, was next called on. She said she had been trying to get material, but nothing had been sent in. The question of what to save was discussed, and Mrs. Hunter said that Mrs. Freeman insisted on every scrap of paper being taken care of. Mrs. Casselman said she did not think all correspondence was important enough to save. Mrs. Hubbard suggested that the President and the Past Presidents get together with Mrs. Hunter and decide what to keep. She has a copy of all mail she wrote. She thought that, if minutes were carefully kept, they would make a good history.

There followed a discussion concerning the publishing of reports in the Journal. The consensus of opinion was that, if reports were sent in, they should be published. A motion was made by Mrs. Nicholson and seconded by Mrs. Epler that the reports of the State Chairmen be published in the next issue of the Journal. Carried.

The President asked whether the Board wished to take any action on the program that Dr. Overton outlined. Mrs. Renner moved that the Board defer action awaiting further developments. The motion was seconded by Mrs. Epler. Carried.

Mrs. McGuire had no report on *Legislation*.

Mrs. Hubbard read her report on *Membership and Organization*. Her committee is planning to make a drive for organizing Auxiliaries in all counties not yet organized and for increasing membership in those already organized. The complete report it attached.

Mrs. Lippincott made the pertinent remark that the men asked for the Auxiliaries, and the House of Delegates voted that every county have an Auxiliary.

Mrs. Renner, speaking of the difficulty in getting new Auxiliaries started, said that in Morris County the women say they have organizations enough. They work for the State Hospital.

Mrs. Thomas P. McConaghy had no report for the *Hygeia* Committee.

Mrs. Theodore Teimer, reporting for the *Widows and Orphans Society*, said that she would continue the same program.

The President said she had turned over to the Treasurer \$25.30, which amount was returned by Mrs. Mason from the Atlantic City fund and has been credited to the Annual Meeting Fund.

Mrs. Dan Renner, *Program Chairman*, said that one definite plan this year is the *Speakers' Bureau*. She called attention to materials which would be helpful in formulating programs; study envelopes from National, booklets from A. M. A. Journal and New Jersey State Department of Health.

Mrs. Hubbard next read her report as a delegate to the National Convention in Cleveland. Her report is filed with these minutes.

Mrs. Lippincott asked a question about the nominating report, and Mrs. Hubbard explained that names of nominees must be in a certain number of months ahead. Mrs. Lippincott thought this method autocratic, but Mrs. Hubbard said the constitution was being rewritten. Mrs. Hubbard said she had copies of the booklet published by the Historian's Committee, "The First Twelve Years", for which she paid 40 cents a copy. Mrs. Lippincott moved that Mrs. Hubbard be reimbursed and that copies be sent to people who need them. The motion was seconded by Mrs. Renner. Motion carried.

In her report, Mrs. Hubbard referred to the letter sent by the Executive Board of the Essex County Auxiliary criticizing Hygeia and presented by her at a Hygeia conference. They asked for specific articles. Mrs. Casselman instructed the Corresponding Secretary to write to the President of Essex County Auxiliary asking her to send a copy of Hygeia and to specify the article to which they objected.

Mrs. Renner asked for suggestions for speakers at the coming meetings.

The President asked for names of any who might make good members of the State Board.

The President then presented the President-Elect, Mrs. Frederick Kinch, and she read her report of the social side of the Annual Meeting at Cleveland, to which she was a delegate.

Mrs. Lippincott made a motion that a vote of thanks be given to Mrs. Hubbard and Mrs. Kinch for their fine reports. The motion was seconded by Mrs. Nicholson. Carried.

Mrs. Hubbard said it was most interesting to note the emphasis put by the States on different projects.

Mrs. Lippincott asked whether Legislation should not be placed under Public Relations Committee, but no motion was made.

Mrs. Casselman said she was much interested in the Recommendations and Resolutions from Mrs. Blake. She spoke of a seeming rebuke to a State Auxiliary for using circular letters, and Mrs. Lippincott explained that in a "Keep Clean Program" in Georgia, Ivory Soap was recommended.

Mrs. Nicholson asked why wives of Navy men have a free membership, as stated in Mrs. Hubbard's report. Mrs. Hubbard explained that they move from place to place and for that reason change their membership often.

A motion for adjournment was made by Mrs. Lippincott and seconded by Mrs. Carlander. Carried.

Atlantic County

Reported by Mrs. James H. Mason, Publicity Chm.

The Executive Board of the Woman's Auxiliary to the Atlantic County Medical Association met at the home of the president, Mrs. James North, on Friday, October 5, 1934. Plans were discussed for a Reciprocity Meeting to which all clubs in the county be invited. Mrs. North appointed a committee to arrange a reception at which pins were to be presented to the five past presidents—Mrs. Charles Kaighn, Mrs. John F. Massey, Mrs. Samuel Salasin, Mrs. James H. Mason and Mrs. Joseph Poland.

Mrs. E. H. Harvey, Chairman of the Widows and Orphans Fund Committee reported no new members. The president suggested that all auxiliary members at least obtain their own husbands as Fund members.

The regular meeting of the Woman's Auxiliary to the Atlantic County Medical Society was held on Friday, October 12, 1934, at the Ambassador Hotel. Mrs. James North presided. Following the reading of the minutes and the treasurer's report, the president gave a report of the State Board meeting of October 8th in Camden.

The Hygeia Chairman reported the distribution of 30 or 40 sample copies of the magazine to various schools and clubs as an advertisement.

The Entertainment Committee reported a surplus from the party given to raise money for past presidents' pins.

It was suggested that each doctor's wife who is a member of the P.-T.A. become a delegate to the State Convention in November or become as active as possible in her own particular unit in order to pave the way for future contact between the public and the doctor.

There being no further business, the president, Mrs. North, presented the pins to the past presidents. A reception was followed by refreshments and cards. Members present—20.

Essex County

Mrs. Edgar A. Ill, Reporter

A luncheon meeting was held by the Auxiliary to the Essex County Medical Society in Bamberger's Restaurant, on October 22, 1934. Mrs. Lou A. Eppler, the President, presided, and seventy-eight ladies were in attendance.

Dr. Edgar A. Ill spoke a few words to impress the importance of doctors urging their patients to have the preschool-aged children immunized and vaccinated so that this work will be done by the family physician in his office instead of being done later in the schools.

Mrs. A. J. Casselman, President of the Auxiliary of The Medical Society of New Jersey, gave an interesting talk outlining the work done by Auxiliaries to medical societies.

Miss Ida Jacobs, of the Maplewood Woman's Club, discussed and demonstrated the artistic arrangement of flowers.

Plans for the Supper Dance for the benefit of the Benevolent Fund have been completed. It is to be held at the Essex County Country Club on Wednesday evening, November 14th. Card playing will

be optional. Mrs. E. H. Snavely is the Chairman and on her committee are: Mrs. C. Zehnder, Mrs. J. Brothers, Mrs. H. Comando, Mrs. J. Echikson, Mrs. S. H. Baldwin and Mrs. R. Kirkman.

Gloucester County

Reported by Mrs. H. B. Diverty, Woodbury

The Woman's Auxiliary of the Gloucester County Medical Society held a Fall luncheon at the Woodbury Country Club, September 26th, at 1 o'clock. The county was very well represented. After the luncheon a social hour was spent at bridge and other games.

At the home of the new president earlier in the month the following program for the coming season was arranged:

Wednesday, September 26—Fall luncheon, 1 p. m. Woodbury Country Club. Mrs. Fuller Sherman and Mrs. Katherine Brewer.

Tuesday, October 23—Card party, 2 p. m. Home of Mrs. J. H. Underwood. Mrs. C. A. Bowersox, Mrs. B. A. Livengood and Mrs. I. J. Stewart.

Thursday, November 15—Business meeting, 9 p. m. Mrs. C. I. Ulmer and Mrs. T. M. Gairdner.

Thursday, December 20—Christmas Party. 2

Thursday, December 20—Christmas Party, 2 p. m. Home of Mrs. E. E. Downs. Mrs. R. L. Moore, Miss Dorothy Underwood, Mrs. H. W. Wright and Mrs. E. E. Downs.

Thursday, January 17—Business meeting, 9 p. m. Mrs. R. K. Hollinshed and Mrs. D. B. Weems.

Thursday, February 21—Old-fashioned party, 2 p. m. Home of Mrs. William Brewer. Mrs. H. B. Diverty, Mrs. P. M. Pegau, Mrs. W. E. Crain and Mrs. William Brewer, chairman.

Thursday, March 21—Business meeting, 9 p. m. Mrs. H. B. Chalfont and Mrs. I. W. Knight.

Thursday, April 18—Spring meeting, 2 p. m. Mrs. C. I. Ulmer and Mrs. D. Campbell.

Thursday, May 16—Picnic. Mrs. C. D. Pedrick, Mrs. W. W. Pedrick and Mrs. F. G. Wandell.

Hudson County

Reported by Mrs. George M. Culver

The first Fall meeting of the Woman's Auxiliary to the Hudson County Medical Society was held at the Y. W. C. A., on the afternoon of Monday, October the first, with the president, Mrs. Frank P. Nicholson in the chair.

The minutes of the previous meeting were read and approved. The treasurer and the corresponding secretary reported on their work. Mrs. Charles B. Kelley, chairman of entertainment, gave a fine report concerning the spring play-day last May. This was a great success, both socially and financially, as we cleared over a hundred dollars.

Mrs. Nicholson spoke of the Executive Board Meeting of the State Auxiliary, which will be held in Camden, on Monday, October the eighth, at ten a. m., at the Walt Whitman Hotel. Hudson County has a new member on this Board, Mrs. Edward G. Waters, of Jersey City. Mrs. Waters has also been appointed as Hudson County chairman of the Speakers' Bureau.

The speaker for the afternoon was Miss Laura Woodruff, secretary of the Hudson County Tuberc-

culosis League, whose advice was "It pays to keep well". She stressed particularly the value of a yearly health examination, and especially for the children, as it is much easier to cope with tuberculosis when you are young, than when the germs become deep seated.

How the league works to prevent the spread of the disease was the special topic of Miss Woodruff. She illustrated her talk with slides—showing first the movies, "The Story of My Life," by Tee Bee, this film shows how the germ gets into one's system, and how hard the system works to resist it, if we are in good physical condition, and how easy it is for the germ to persist and undermine our constitution, if it enters at a time when our health is at a low ebb.

Miss woodruff then showed slides of the summer camps, Camp Hudsonia, near Hibernia, which is for girls, and Star Lake Camp, which is for boys, and also the Preventorium at Farmingdale.

Tea followed the program, Mrs. E. J. Chapman being chairman of hostesses, assisted by her committee.

Reported by Caroline Culver, for the Hudson County Auxiliary to the Medical Society.

Monmouth County

Reported by Mrs. W. K. Campbell, President

The quarterly meeting of the Woman's Auxiliary to the Monmouth County Medical Society was held Friday, September 28th, at the Roosevelt Tea Room, Little Silver. Following luncheon a business session was held, with the President, Mrs. William K. Campbell, of Long Branch, presiding.

The guest of honor and speaker was the State President, Mrs. A. J. Casselman, of Camden, who told of the history of the Auxiliaries and gave a practical outline of work which the county group is particularly fitted to do. She suggested that the Auxiliary form an agency for a Speakers' Bureau, and also become better informed with the relief measures for the widows and orphans of medical men of New Jersey.

Other newly elected officers of the Auxiliary include Mrs. Robert McKenzie, of Asbury Park, Vice-President; Mrs. Murray Woronoff, of Keyport, Treasurer; and Mrs. Otto R. Holters, of Asbury Park, Secretary. New committee charimen are Mrs. Walter Gosling, Red Bank, Publicity; Mrs. James Fisher, Asbury Park, Nominating Committee; Mrs. Sidney L. Neiderhoffer, Long Branch, Membership; Mrs. Harry Ingling, Freehold, Widows and Orphans; Mrs. Stanley Nichols, Long Branch, Hygeia; and Mrs. Kenneth Brown, Asbury Park, Public Relations.

Members present besides those mentioned were: Mrs. W. F. Donovan, of Brielle; Mrs. R. E. Watkins, of Belmar; Miss Reynolds, of Freehold; Mrs. J. E. Maher, of Long Branch; and Mrs. C. Byron Blaisdell, of Long Branch.

The next meeting will be in Long Branch November 30th, and the speakers will be Dr. John E. Maher, President of the Monmouth County Medical Society; and Mrs. Theodore Teimer, of Newark, State Chairman of the Widows and Orphans Society.

Passaic County

Reported by Mrs. H. Dawson

A regular meeting of the Woman's Auxiliary to the Passaic County Medical Society was held on Monday at the Paterson Woman's Club. An interesting talk was given by Frank Rich, Principal, on the special health work carried at School No. 2, which was enjoyed by all present. An invitation was extended to all to visit the school and see the fine work that is being accomplished. It was agreed to accept the invitation and all the members wishing to attend are to meet there on Monday, October 29, at 1 p. m.

The following members were present: Mrs. B. Botbyl, Mrs. S. Chester, Mrs. E. Leonard, Mrs. H. Cogan, Mrs. W. Neer, Mrs. E. Tuers, Mrs. J. Phelps, Mrs. R. MacDonald, Mrs. H. Nye, Mrs. L. Taber, Mrs. A. Dwyer, Mrs. T. Graham, Mrs. A. Pelusio, Mrs. A. McBride, Mrs. F. Ash, Mrs. M. Chapnick and Mrs. H. Dawson.

Somerset County

Reported by Mrs. Charles F. Halsted

A meeting of the Woman's Auxiliary to the Somerset County Medical Society was held Thursday, October 11th, 1934, at Blue Hills Plantation at 12 o'clock noon, the President, Mrs. Lancelot Ely, presiding.

In the absence of the Secretary, Mrs. A. A. Lawton was appointed Secretary pro-tem. The minutes of the June meeting were read and approved. Mrs. E. T. Flint, our Treasurer, gave her report, which was accepted as read.

Mrs. Renner reported on the Fall meeting of the Executive Board of the State Auxiliary, and read a letter from our State President, Mrs. Casselman, stating her projects and program for the year.

The Constitution and By-Laws were also presented and adopted.

Those present were: Mesdames Ely, Stillwell, Flint, Lawton, Renner, Fisher, Hegeman, Meigh, Anderson, Sperra, Borow, Piggott, Adams, East, and two new members welcomed: Mrs. Hamblin and Mrs. A. S. Knight.

The members adjourned to the dining room where they were guests of the Medical Society at its annual dinner.

Union County

Reported by Mrs. Frederic A. Kinch, Chairman, Publicity Committee

The regular meeting of the Woman's Auxiliary to the Union County Medical Society for October was omitted on account of the passing on of Dr. Freind B. Gilpin, of Cranford, husband of our President-Elect and brother of our Treasurer, Mrs. George S. Laird.

The postponed Board meeting was held Tuesday, October 16th, at the home of the President, Mrs. H. H. Bowles, in Summit.

Plans were discussed for a reciprocity meeting and tea to be held in Elizabeth at Carteret Arms some time in November.

A membership drive was planned, and the members of the Board were asked to secure a list of the wives of the medical men of the county and report at the next Board meeting.

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		ANDREW F. MCBRIDE (1937)	Paterson

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Second District (Sussex, Bergen, Hudson and Passaic Counties)	CHARLES B. KELLEY, Jersey City (1935)
Third District (Mercer, Middlesex, Somerset and Hunterdon Counties)	F. G. SCAMMELL, Trenton (1937)
Fourth District (Camden, Burlington, Ocean and Monmouth Counties)	JAMES A. FISHER, Asbury Park (1936)
Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties)	ALDRICH C. CROWE, Ocean City (1935)

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A. HAINES LIPPINCOTT, Camden	" " 1935	STEPHEN T. QUINN, Elizabeth	" " 1935
WALT P. CONAWAY, Atlantic City	" " 1936	PHILIP MARVEL, Atlantic City	" " 1936
JOHN F. HAGERTY, Newark	" " 1936	LUCIUS F. DONOHUE, Bayonne	" " 1936

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CLARENCE L. ANDREWS, Atlantic City	" " 1936
LOUIS C. LANGE, Weehawken	" " 1937

Program and Arrangements

WILLIAM J. CARRINGTON, <i>Chm.</i> , Atl. City ..	Term expires 1935
WILLIAM D. OLMSTEAD, Atlantic City	" " 1936
JOHN W. GRAY, Newark	" " 1937
LANCELOT ELY, Somerville	Ex-officio
J. BENNETT MORRISON, Newark	Ex-officio

Publication

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LINN EMERSON, Orange	" " 1935
EDWARD J. ILL, Newark	" " 1937
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J. BENNETT MORRISON, Newark	Ex-officio

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JAMES S. GREEN, Elizabeth	" " 1935
HERSCHEL PETTIT, Ocean City	" " 1936
WILLIAM G. HERRMAN, Asbury Park	" " 1937
WILLIAM J. SWEENEY, Weehawken	" " 1938
ALFRED STAHL, Newark	" " 1940

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The following program was presented at the Clinical Society meeting at the New York Polyclinic Medical School and Hospital on October 1st, 1934:

1. Treatment of Brain Abscess (lantern slides). Joseph E. J. King, M.D.
2. Advantages of Electrosurgical Obliteration of the Gall-Bladder Over Classical Cholecystectomy (motion pictures). Max Thorek, M.D., Chicago.

The following program was presented at the Clin-

ical Society meeting at the New York Polyclinic Medical School and Hospital on November 5th, 1934:

1. Amoebic Dysentery. Damaso de Rivas, M.D., University of Pennsylvania.
2. The Use of Artificial Pneumothorax in the Treatment of Lobar Pneumonia. Francis G. Blake, M.D., Yale University.
3. Medico-Zoological Aspects of the Race Problem. Colonel C. W. Stiles, U. S. Army, Washington, D. C.

Dr. Murray B. Gordon, Adjunct Professor of Pediatrics, is giving a series of six lectures on Endocrinology in Children, on Tuesdays at 3:30 p. m., starting November 13th, 1934.

A CHRISTIAN SCIENCE VIEWPOINT

An editorial in the July issue of the Ohio State Medical Journal has the following quotation from the *Christian Science Monitor*, whose article is entitled "Medical Peonage":

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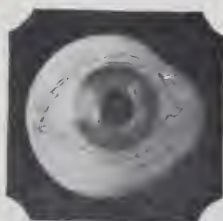
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OF

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DECEMBER, 1934

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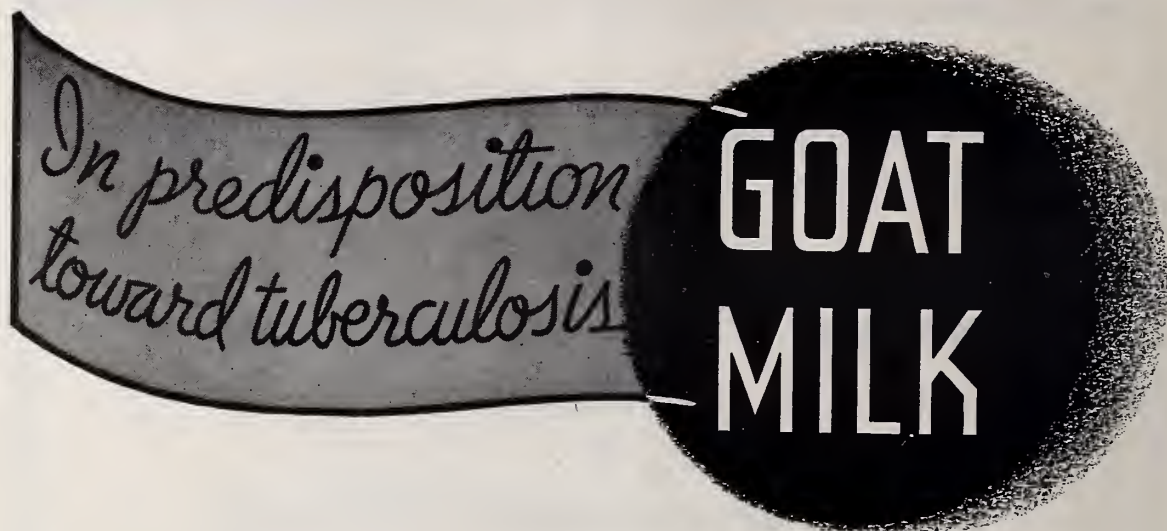
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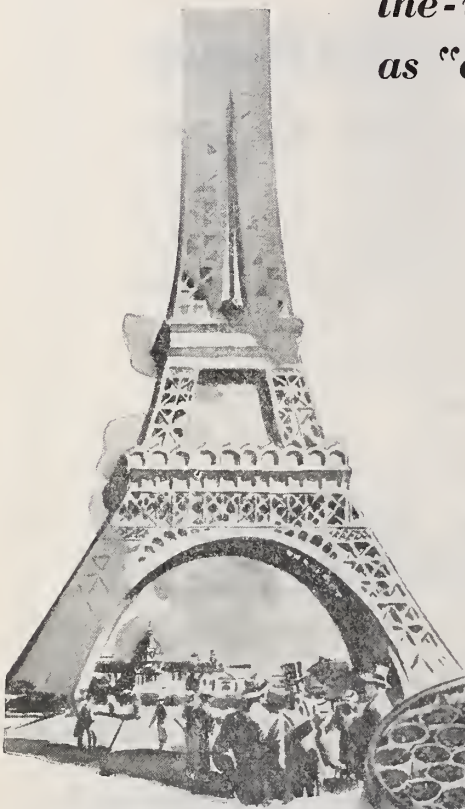
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



EDITOR OF
THE JOURNAL
FRANK OVERTON, M.D., Dr. P.H.

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Articles and other material for publication, and also communications relating to reprints, subscriptions, advertisements or other business matters, should be sent to the Editor.

Officers, Trustees, Councilors and Committees of the Society are listed on page xx of the Advertising Section.

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DECEMBER, 1934

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EDITORIALS

A New Jersey Plan for 'Health Security'

The nation-wide discussion of the relation of economic conditions to the distribution of all forms of medical services to all classes of society culminated in the announcement of a committee of the Federal Government to devise a national *Plan for Economic Security*, which was briefly outlined on page 651 of the November issue of this Journal. The reference to the subject made by President Roosevelt in his address before a conference of that committee and invited guests was reassuring to both the medical profession and the public; and his appointment of a representative *Medical Advisory Committee* was an indication that he expects the physicians to devise a definite plan of organization and effort in order to meet the situation in such a way that no "unfair burden shall be placed upon the Medical Profession".

The plan of correlating *medical services* with *economics* may be approached from the standpoint of either subject. The approach of the Federal plan was through the avenue of *economics* which had been opened up and publicized largely by the national Committee on the Costs of Medical Care and the great "Foundations".

The Medical Society of New Jersey has approached the problem by the avenue of *medical service*, the theory being that if physicians will determine what medical care is needed and will devise a plan for supplying the need, the costs of the services will be met as a natural obligation.

New Jersey is a peculiarly favorable State in which to develop a plan of medical service which shall be satisfactory to both the medical profession and the public, for its state medical society has established and operated the two great projects of the *Emergency Relief Administration*, and the *Public Health Hour*.

That The Medical Society of New Jersey can devise methods for the equitable distribution of medical services in all lines of practice was the unanimous opinion of a group of leaders that met informally on November 21, 1934. It was also the opinion of the medical leaders that physicians would be willing to contribute their quota of organized service for the administration of any plan which they may devise, just as they are now contributing their services on E. R. A. committees in their respective counties, and in the services of the Public Health Hour.

Co-operation of Medical and Lay Groups

President Ely and Chairman Nichols of the Public Health Committee made plans to secure fifty physicians to attend the annual New Jersey Conference of Social Workers in Asbury Park, on December 7, 1934, in order to observe the proceedings, and if necessary take part in the discussions and explain the point of view of practicing physicians. This was a part of a comprehensive plan to bring these two groups, the medical profession and the social and welfare workers, into closer agreement and understanding regarding their common objectives, and to develop methods of mutual coöperation.

The two groups of medical and non-medical workers have followed the line of least resistance in developing their plans. The major activity of medical societies has been along purely scientific lines; and technical medicine is still the principal subject discussed in ninety-five per cent of their meetings. There has naturally been little or no incentive for laymen to attend a meeting of a medical society, except an occasional one of a recreational nature.

The social and welfare workers, on the other hand, have developed the programs of their meetings with little reference to the medical profession; but in justice to them it must be said that there has too frequently been a woeful lack of interest when they have invited physicians to address them. They have, therefore, developed their own philosophy of service, which has often not been in accord with that of the medical profession.

Social workers consider the ills of mankind—physical, mental and social—in the mass, and impersonally. Sickness, to them concerns the *group* or the *community*. They look on tuberculosis, for example, in the light of the number of cases in their city or county, and of the number of sanatoriums and clinics for its detection and treatment. They hear of new types of institutions and new methods of treatment which are described in periodicals and pamphlets and cannot understand why doctors should not enthuse over them.

Physicians, on the other hand, consider each

disease as an entity, and each sick person as an *individual*. A doctor treats the sick *person* rather than his disease, and considers the personality, the preference, the likes and the dislikes of his patient. He strives to adapt his advice and suggestions to the ability and willingness of the patient to carry out his directions.

The doctor is also a good "mixer". He meets persons of all classes and means, and knows their attitude toward civic activities which require taxes, subscriptions, and effort for their support. He understands the psychology of the people far better than do the social workers. He foresees the difficulties in the way of the realization of the ideals of the social workers. He would accomplish *mass* action by the slow but sure process of educating the individuals of the community, both the sick and the well.

There is really not so much *conflict* between the medical and the lay workers as might be supposed. Each group can soon learn to look at a problem from the point of view of the other group. In order to secure harmony and coöperation two measures are necessary:

1. The social workers shall attend some meetings of medical groups.
2. Physicians shall attend some meetings of the social group.

A social worker is out of place in an ordinary meeting of a medical society. But a medical society can periodically put on a program on economic and social topics and invite lay workers to speak and take part in the discussions. An example of this kind of meeting is that of the joint meeting of the Bergen County Medical Society and the Pharmaceutical Society of the county, to which references are made on pages 674 and 710 of this Journal. This meeting was also unique in that it was the druggists who occupied the leading places on the program. Such a meeting is illuminating to both groups.

A physician is also likely to feel ill at ease in a meeting of a lay social organization; but that is the very reason why he should attend the meetings and learn the point of view of

the social group at first hand. The good results of such a course is illustrated by the action of a dozen highly individualistic doctors of a certain village who ended a long feud with the welfare workers by forming an association and meeting with the Board of Education and the Parent-Teachers Association, and quickly reaching an agreement on a method of immunizing the school children against diphtheria that was satisfactory to both groups.

The leaders of The Medical Society of New Jersey planned to set an example to physicians by attending the representative conference of

the Social Workers of the State, both as listeners and as active participants in the discussions. The results of this meeting should have far-reaching effects on the activities of physicians in the meetings in their home communities.

It is suggested that the above editorial be made a major topic of discussion by every County Medical Society at an early meeting.

LANCELOT ELY,
HENRY C. BARKHORN,
Chairman President,
The Medical Society of
Publication Committee New Jersey

Times of Taking Office

The dates on which county society officers assume office was discussed at the Conference of County Secretaries and Reporters, and by the Board of Trustees. The close association and coöperation that exist between the officers of the State Society and those of the county societies is interrupted by the present system by which the change of officers occurs in the late Fall in most county societies, while the officers of the State Society are changed in early Summer just after the Annual Meeting. The summer period of society inactivity enables the new state officers to make their plans for the year's work; and then in early Fall the activities start up in full force and continue without interruption through the rest of the year.

Most county societies, on the other hand, elect and install their officers in the late Fall, just when the State Society activities are well under way. The officers whose terms will end are reluctant to start new projects which will soon pass into other hands; and those who succeed them require some time to become familiar with their duties and the problems which they face. The work of the State Society often suffers from a break in its continuity, and valuable time and effort are required to instruct the new county officers in their duties.

Making the terms of all officers, both State

and County, begin and end together would not only prevent confusion and delay, but would also promote efficiency of action. The argument for the change is not based on convenience, although that would be entirely proper. It is based on the results of sustained action, and on the morale which develops through an unbroken year of service with the two hundred or more officers and committeemen of the State Society.

An argument for the change is found in the May Journal, page 277, in which Dr. Satchwell, Chairman of the Committee on Hospitals and Medical Education, in his annual report, said:

"In the past the contact of the State Committee with each county society has been through a committee which is usually appointed so late in the year that the State Committee is unable to start its activities until after January first."

The work of most committees of the State Society is done in close contact with similar committees of the county societies; and it is extremely desirable that the terms of service of all of them should be synchronous.

The Monmouth County Medical Society has already filed the proposal of an amendment to change the time of electing and installing its officers to the Springtime instead of the Fall.

Physicians, Pharmacists, and Patients

The Bergen County Medical Society held its November meeting jointly with the County Pharmaceutical Association. (Page 710.) The pharmacists contributed the greater part of the program, and told the doctors about some of their responsibilities in the distribution of drugs and pharmaceutical preparations. The druggists gave excellent arguments in refutation of the alleged promotion of self-medication by their customers. While none of the arguments were new, they were well received by the physicians because they were presented in a logical form which revealed some of the practices by which physicians have innocently promoted self-medication by the patrons of the drug stores. Among the acts of physicians enumerated and discussed were the following:

1. Dispensing "samples" bearing descriptions of their alleged effects on common symptoms, thus encouraging their patients to call for the same preparations when the symptoms recur. Many packages of preparations dispensed in cut-rate drug stores are "samples" obtained from physicians.

2. Prescribing chemicals under their proprietary names, when the same active articles under their scientific names could be sold at a greater profit to the druggist at a quarter of the cost. (This is one of the complaints under the E. R. A.). For example, druggists carry 68 preparations whose active ingredient is *cas-car-a sagrada*.

3. Prescribing new preparations which salesmen promote, and which have a temporary vogue and are then forgotten, leaving the druggist with his shelves filled with unsalable articles.

4. Suggesting what a prescription may cost, especially one containing a drug which is expensive because of its proprietary name. A

doctor would resent a criticism by a druggist regarding the price which he should charge a patient for a consultation.

5. Popularizing new remedies and applications when the old standard ones are just as effective and far cheaper (tincture of iodine for superficial wounds, for example).

6. Failure to protest against public advertisements in which alleged opinions of physicians are quoted in such insinuations as "used by the medical profession for fifty years".

7. Accepting a lengthy list of pharmaceuticals whose very names fill hundreds of pages of catalogues, when only half a dozen pages would be required to list those which are really necessary.

The speakers gave figures showing that the average druggist conducts his prescription department at a loss because of the expert help that is required, and the multiplicity of unnecessary preparations for which there is seldom a call.

One speaker called attention to the services which a druggist may render to both the patron and the physician by suggesting a periodic health examination to a customer who asks for "something good" for a condition from which he seeks relief.

The meeting was a revelation of the common ground on which physicians and pharmacists may meet to the great benefit of both professions as well as the public. New Jersey is almost unique among the states in that its pharmacists are organized in an active state society which has component branches in the counties similar to the county medical societies. Plans were suggested by which pharmacists may contribute informative articles to appear in the State Journal during the coming year.

Reporting Communicable Diseases

The suppression of communicable diseases requires the coöperation of two groups of persons:

1. Physicians who make the diagnoses and deliver medical services to those affected.

2. Departments of Health, which perform the administrative duties by which the personal activities of the physicians are coördinated and made effective.

There are always two parties to be consid-

ered in suppressing or preventing communicable disease.

1. The patient and his family.
2. The public.

A patient employs a physician to be his private advisor, just as he employs a lawyer to present his side of a case to the court. But the law of reporting requires the doctor to disregard his ordinary obligation of secrecy to the person who employs him, and to make a public report of the existence of a communicable disease in his private patients. His report may subject the patients and his family to the restraint of their liberties without their having the opportunity to be heard in defense according to the ordinary procedures of law. Every case of communicable disease is considered as an emergency which justifies extra-legal measures.

There is, therefore, a grave responsibility resting upon a physician in reporting a case of communicable disease; and he is often in a dilemma. He may emphasize the point of view of the patient and delay his report until the disease is evident, even to a layman. On the other hand, he may consider the possible danger to the public and report his suspicion that a disease *may* be present, and then have to change his diagnosis to his own condemnation.

The common knowledge of people regarding the more contagious diseases has created a public opinion that the family doctor should make known his suspicions that a patient may have such a disease as smallpox, or measles, or scarlet fever. However, an eruption proclaims these diseases to anyone who sees the patient, and acts as a red flag of warning to visitors and a justification of the doctor in his reporting.

Theoretically *every case of every kind* of communicable disease should be reported to the health department; but such a requirement would be impossible to carry out, and attempts to enforce it would defeat the very object for which it is designed.

In order that a regulation making any disease reportable may be effective, certain basic

principles regarding the disease must be considered.

1. The *identity* of the disease must be evident. Sore throat is not a disease entity; and yet it may spread as an epidemic from a single source. Boards of health often adopt a compromising course by making the conditions reportable only when a considerable number of persons in a restricted locality are affected. This course may not be entirely scientific, but it is based on sound psychology of the public.

2. *Ease of recognition.* Proof of the existence of a disease depends upon two kinds of evidence:

- a. Clinical.
- b. Laboratory.

Clinical evidence must usually be present before a doctor will be called to examine a patient, or before a patient will submit to having a specimen taken for a laboratory examination. In most diseases for whose diagnosis a laboratory examination is essential, few cases will be discovered unless clinical symptoms are evident.

3. *Communicability.* People take but little interest in preventing the spread of a disease whose communicability is not great and which is not likely to spread under the ordinary contacts of one person with another. Very little will be accomplished by reporting a disease unless practically all the cases are discovered. Cities may be able to arouse the people to submit to reporting diseases which have only a mild degree of contagiousness; but their state-wide reporting is well-nigh impossible.

Standards. Reporting a case of a disease implies its compulsory control. A physician objects to being made a party to the imposition of irksome regulations upon a person unless a definite object will be obtained. Instead of adding to the list of diseases to be put under compulsory regulations, a physician would welcome the plan of setting up *standards* for the public recognition and prevention of the debatable diseases, and inviting the public as well as the physicians to conform to them voluntarily. Education of the public must precede the imposition of regulations.

The Doctor's Secretary

The physician's office secretary is an important personage to the public as well as the physician. She is a large factor in the formation of public opinion regarding her employer and the entire medical profession. She is often the laboratory technician to the doctor and on her often depends his accuracy of diagnosis. She is also his literary secretary and attends to his mail and correspondence, and may assist him in his medical reading and in editing articles which he writes—and this is only a partial list of duties which a medical secretary performs.

The qualifications of a good medical secretary begin with the *temperament* with which she is naturally endowed. If she does not have a natural adaptability for making contacts with all sorts of persons in their times of worry and trouble, she will fall short of the requirements of the secretary to a busy

doctor who bears the burdens of his patients as well as his own. But the position requires training and experience which the doctor who is most in need of a secretary has the least time to give.

The question of training is solved by the Westbrook Junior College, Portland, Maine, which has established a two-year course for medical secretaries, which is described in a two-page article in the *New England Journal of Medicine* of September 6, 1934. The lines of instruction are both technical and secretarial, and fit the student to perform the general duties of office nurse, technician, and secretary. The course is planned and supervised by a committee of members of the Cumberland County Medical Association, and a final examination is given to the graduating class by another committee. Thirty-six students are enrolled in the course.

Armistice Day

Armistice Day, Sunday, November 11, 1934, was of peculiar significance to physicians because of the note of pacifism in many of the sermons that were preached. Doctors agree with the preachers in their desire to abolish war, but they do not believe that a recital of its horrors will deter politicians from creating the causes of war, or from fomenting quarrels between nations. At any rate, physicians recoil at a recital of the gruesome aspects of war. A soldier shrinks from talking of the grisly features of a battle, just as the surgeon keeps silence regarding the spectacular events that take place in an operating room.

Physicians are equally annoyed by florid accounts of the bravery of the soldier, his heroic deeds, his self-sacrifice, which are often the feature of Armistice Day celebrations. None of these sentiments are present in the mind of a soldier fighting on the battle field, or a surgeon in the operating room. The predominant emotions of both the soldier and the surgeon is *anxiety*, concealed with trivial remarks and mannerisms that may seem far from uplifting and inspiring to the soul.

The medical service of the army was life-saving and humane, and physicians entered it not to destroy, but to save life. How well they succeeded is shown by the reversal of the former ratio of deaths from disease compared with those from battle wounds. The talk about the cruelty and inhumanity of warfare does not apply to the medical officers and the privates enlisted under their command.

This *Journal* of February, 1919, contains the names of 502 members of the Medical Society of New Jersey who were serving in the World War. A complete list was promised for the annual meeting in June of that year, but it was not published. Inquiry at the office of the Adjutant General at Washington elicited the reply that no list of Reserve Officers had ever been compiled by states.

The membership of The Medical Society of New Jersey in 1919 numbered 1753; and more than one-third entered the medical service of the World War. They seldom mention their experiences; but physicians would enter the service again tomorrow if the need were present.

ORIGINAL ARTICLES

ERYTHROBLASTOSIS OF THE NEWBORN

By ROBERT R. WHITE, M.D., East Orange, N. J.

Read before the Section on Pediatrics at the Annual Meeting of the Medical Society of New Jersey in Atlantic City, June 6, 1934

The term, erythroblastosis, has of late been used to embrace three definite clinical syndromes, i. e.—congenital anemia, icterus gravis neonatorum, and congenital hydrops (universal edema of the newborn). The syndromes described as universal hydrops and icterus gravis neonatorum have been recognized for many years, and have been considered as a mysterious and highly fatal group of diseases afflicting the newborn infant, but the inclusion of the anemia type in this group has only recently been pointed out. That they are all closely related histopathologically, that they are dependent upon the same underlying pathological process, and that the conception of a certain sequence of events leading to the development of each symptom-complex is justified, have been clearly shown by Diamond, Blackfan and Baty in 1932.⁽¹⁾ Their study helped to clarify a rather confusing group of apparently unassociated conditions, aiding classification, thereby simplifying and organizing the treatment of infants who would otherwise be mis-diagnosed and lost. The writer's interest in these cases was aroused in the Boston Lying-In Hospital by having delivered four such infants, who were reported in the work of Clifford and Hertig in 1932.⁽²⁾ The purpose of this article, then, is to bring forward such information from literature and practical experience as may stimulate interest in the early recognition and thorough investigation of these infants.

REVIEW OF THE LITERATURE

In 1898, Ballantyne⁽³⁾ collected seventy cases of universal edema of the fetus, which had occurred subsequent to 1614. He noticed among other things enlargement of the liver and spleen, which pointed probably to a disturbance of the blood in these cases. Swart (1905)⁽⁴⁾ reported unusual blood-forming foci

in the liver, spleen and kidneys in an infant with general edema. Schridde (1910)⁽⁵⁾ first suggested a causative disturbance of the hematopoietic organs in certain types of universal edema of the fetus. Rautmann (1912)⁽⁶⁾ termed the underlying condition, erythroblastosis. Goormaghtigh (1925)⁽⁷⁾ described and illustrated extensive erythroblastic proliferation and infiltration. Reports of this fetal type of dropsy were becoming very numerous, and the criteria common to all were general edema, enlargement of the liver and spleen, evidence of anemia in the tissues, icterus, extensive extramedullary blood-forming islands, and enlargement and edema of the placenta.

Regarding icterus gravis neonatorum, Hampson (1929)⁽⁸⁾ and others have reported a large number of cases. They mentioned the familial evidence, severity of the icterus, the unfavorable prognosis, the presence at birth of large numbers of nucleated erythrocytes in the peripheral blood, and the greatly enlarged liver and spleen which contained numerous areas of hematopoiesis. De Lange and Armtzenius (1929)⁽⁹⁾ called attention to the occurrence of yellow-colored amniotic fluid and the vernix caseosa of a saffron-yellow hue at the birth of patients suffering from this disease. From these reports, the criteria for the diagnosis of icterus gravis neonatorum were familial incidence of early and severe jaundice, anemia, abnormally large numbers of nucleated erythrocytes in the blood, enlargement of liver and spleen and extramedullary hematopoiesis to an extraordinary degree. Ferguson (1931)⁽¹⁰⁾ published an excellent description of the pathological changes in five cases of erythroblastosis fetalis with and without edema, presenting in common the following findings: enlargement of liver and spleen, usually generalized edema, jaundice, pallor of body tissues, large numbers of circulating nucleated erythro-

cytes, extraordinary blood-forming activity in the liver, spleen, kidneys and other organs, and enlargement and edema of the placenta.

Priority for the description of anemia alone is generally credited to Ecklin (1919)⁽¹¹⁾ who published a case of severe anemia in the newborn. Since that time many investigators have found infants suffering from this disturbance. All examples do not conform to the criteria found in the condition as it is now recognized, but they describe severe pallor and anemia occurring shortly after birth, the early presence of large numbers of immature red blood cells, mostly reticulocytes, often enlargement of the liver and spleen and, at autopsy, extramedullary hematopoiesis of abnormal degree in various organs, and in addition the occurrence of early or severe jaundice which was noted in a few cases. The correlation between congenital hydrops and icterus gravis was suggested after 1929,⁽¹²⁾ and the possible relationship between the anemia of the newborn and the erythroblastosis is still an open question, but has been clarified by the work of Diamond, Blackfan and Baty (1932).⁽¹⁾

INCIDENCE

The incidence of congenital hydrops ranges from 1 in 1200 to 1 in 3000 births, according to various reports. Icterus gravis has been considered rare, but no actual statistics are available. The writer, however, saw 7 proved cases over a period of 9 months at Boston Lying-In Hospital, and during this period of time 2400 births occurred, making an incidence of 1 in 340. Thus it is probably a fairly common condition.

THE DISEASE PROCESS

The etiology of the disease is still unknown, but the process appears to be a disturbance in the metabolism of the hematopoietic system, resulting first in either a failure of maturation of erythrocytes or in an overgrowth of immature forms of erythrocytes; second, in the delivery of immature nucleated erythrocytes in large numbers to the peripheral circulation; and third, in the increased destruction of erythrocytes including nucleated forms. An unknown stimulus asserts itself in late uterine

life as a prolongation of or reversal to the embryonic system of blood formation. Consequently, abnormally young forms appear in the blood stream, and along with this there is an abnormal blood destruction. Congenital hydrops represents a more chronic and severe form with widespread erythropoiesis of early embryonic type showing numerous erythroblasts and less normoblasts. Icterus gravis shows widespread erythropoiesis but with fewer early erythroblasts and evidence of more acute red blood cell destruction. The anemia shows far fewer normal forms and less evidence of blood destruction.

Erythroblastosis runs the major portion of its course in utero and in the first few days of life. It is not common to any particular race or sex, and is not related to tuberculosis, toxemia, or anemia in the mother. The first-born usually escapes the disease.

PATHOLOGY

The morbid anatomy may be described as a persistence of or reversal to the fetal type of blood formation, and falls into two main groups: those having edema as the main feature and those with a varying degree of jaundice. Those with edema show marked effusions into the serous cavities, a waxy pallor of the skin, marked anemia, enlargement of liver and spleen, an enlarged heart, and a placenta often firm, pale, and at times enlarged to 2 or 3 times its normal size. The striking feature microscopically is the marked erythropoiesis found in spleen, liver, pancreas, adrenals, kidneys, prostate, thymus, pituitary and placenta. Red blood cells in all stages of production from the erythroblast to the erythrocyte, polychromatophilic cells, reticulocytes, myelocytes and myeloblasts are found everywhere in the blood vessels.

Those patients presenting jaundice and more or less anemia show little edema (if any), generalized jaundice (though this may be absent), heart enlargement, enlargement of the spleen 4 to 5 times its normal size, as well as the liver 2 to 3 times normal size. The extra-hepatic bile ducts are normal. The brain is frequently icteric, and the nuclear elements are deeply pigmented, a condition described as

"kernicterus". The placenta is normal in appearance or enlarged $1\frac{1}{2}$ times, and is neither pale nor firm. Microscopically the process is the same as in the former group, but less severe and of more mature type. More normoblasts and myeloblasts are found, and less erythroblasts. Hematopoiesis is more marked in the liver, spleen and marrow, and phagocytic action in the spleen is easily seen. In the liver large numbers of islands of hematopoiesis are scattered throughout the parenchyma. They are located chiefly in the sinusoids and in the periportal spaces, compressing the liver columns and replacing the liver cells. Some liver cells show early vacuolization and many bile ducts are dilated and filled with bile casts.

CLINICAL TYPES

1. *Universal Edema of the Fetus with Erythroblastosis.*

At birth, the obstetrician is confronted with an infant usually covered with a thick golden-yellow vernix caseosa, with a waxy white skin, and a varying degree of generalized edema of the entire body. Respiration is started with difficulty, and when initiated is very irregular, gasping in type and soon ceases. The infant may be stillborn, premature, or associated with hydramnios. Cyanosis does not develop on account of the severe anemia. Jaundice is usually absent or of very mild degree. The abdomen is full and prominent due to enlargement of liver and spleen, and ascitic fluid amounts sometimes to 500 c.c. The heart is hypertrophied at times to twice its normal size. The umbilical cord is edematous, and the placenta is pale, thick, edematous, and may be twice the normal size. The red blood cell count may be below 500,000. The total nucleated cell count is between 5,000 and 297,000, and 50 per cent to 90 per cent of these are nucleated red cells.

2. *Icterus Gravis Neonatorum with Erythroblastosis.*

In our experience the infants of this group have always been covered with golden-yellow vernix and accompanied by yellow-colored amniotic fluid. Icterus of a mild degree is nearly always present, the liver and spleen are palpably enlarged, and the heart is usually hyper-

trophied. The placenta is considerably enlarged but may be of normal color. These babies do not die as quickly as the ones showing edema and pallor. A blood smear taken immediately shows large numbers of nucleated red blood cells. Petechial hemorrhages covering the upper trunk and head show the marked tendency to bleed, and more extensive hemorrhages may take place subsequently in various parts of the body. Jaundice increases rapidly, becoming intense at the end of 48 hours when severe respiratory distress develops, characterized by labored, grunting respiration and spells of cyanosis which soon become continuous. Extensive hemorrhages may now develop in any of the body cavities, with the appearance of blood at the mouth or in the urine. Sometimes during the first 5 days the infant suddenly passes into severe shock and dies. The condition carries with it a moderate anemia marked by jaundice and cyanosis. Red blood count is between 2,000,000 and 4,000,000. The total nucleated cell count is increased and may exceed 100,000, a large percentage of which are nucleated red cells.

3. *Anemia of the Newborn with Erythroblastosis.*

Formerly these cases were indefinitely described as Idiopathic Anemia of the Newborn. According to the investigations reviewed in this paper the tendency is to classify them as an early phase in the process known as erythroblastosis. Many studies are now working on the relationship between the anemia of erythroblastosis, particularly that which persists long after acute symptoms have disappeared, and idiopathic anemia of the newborn.

At birth the infants appear normal. Pallor is noted several hours to several days after birth. Jaundice may appear on the first or second day, or may be absent. Edema is absent. Liver and spleen are palpable. Petechial hemorrhages may occur, and examinations of the blood reveal a severe progressive anemia. The red blood cell number is from below 1,000,000 to 2,500,000. The hemoglobin concentration is lowered, but the color index is one or over, showing the existence of hyperchromia. This has been substantiated by stained smears which show well-filled erythrocytes and macrocytes.

DIAGNOSIS

It is readily seen that the attending obstetrician occupies the most advantageous position to make the diagnosis of erythroblastosis. A presumptive familial history may give a lead to suggest a repetition in the case at hand. If the infant is edematous, pale, jaundiced, covered with yellow vernix caseosa, accompanied by yellow amniotic fluid or a large placenta, suspicion of erythroblastosis is immediately aroused. The infant should then be examined for full abdomen, fluid, large liver, spleen or heart. An immediate blood smear adds much evidence if the total nucleated count is increased, and if differential count shows an abnormal number of nucleated red blood cells.

Standards for the normal blood picture of the newborn infant, according to Lippman,⁽¹³⁾ are as follows: total nucleated count (w.b.c. count) below 20,000-25,000; nucleated red blood count may be 5 per cent at birth, and should drop below 1 per cent by the second day; average red blood count at birth is 5,200,000 to 5,600,000, and at one week 4,000,000 to 5,000,000. An abnormally high nucleated red cell count alone is not sufficient to diagnose conclusively erythroblastosis of the newborn, for this finding has been observed in congenital heart disease and syphilis without evidence of erythroblastosis.

Golden-colored vernix caseosa and hypertrophy of the placenta have also been seen in cases with enlarged hearts and increased nucleated red cell counts, but without erythroblastosis at postmortem examination. The golden vernix has also been present in a few apparently normal babies; its true significance is not yet known.

DIFFERENTIAL DIAGNOSIS

At the present time it is possible to make the positive diagnosis of erythroblastosis only after histopathological examination of the tissues. There are several other conditions which are easily confused with it.

Icterus Neonatorum: A mild jaundice appearing on the second or third day in an infant not acutely ill, neither presenting anemia, edema, bleeding, dyspnea, nor cardiac, hepatic

or splenic hypertrophy. It does not present the blood picture of erythroblastosis.

Congenital Obliteration of Bile Ducts: This diagnosis becomes definite as the course is followed. Slight jaundice may be seen at birth, but does not reach its maximum intensity for 2 or 3 weeks. The liver is enlarged, and there may be hemorrhages, but neither edema, dyspnea, cyanosis, cardiac nor splenic hypertrophy are present.

Jaundice Associated with Sepsis: Cases showing jaundice as the result of sepsis in the newborn are difficult to differentiate from icterus gravis neonatorum; in fact many cases of the latter have no doubt been considered sepsis of the newborn. The two conditions may exactly simulate each other, but the jaundice of sepsis usually appears later than that of erythroblastosis. Many cases of sepsis are afebrile, while erythroblastotic babies may run a high fever for several days. A positive blood culture in erythroblastosis may be obtained in the presence of terminal infection. Both conditions have enlarged livers and spleens, and the blood picture in sepsis has not been sufficiently studied to show the differential value of an increased nucleated red cell count. The differential diagnosis, then, can only satisfactorily be made at the post mortem examination.

Congenital Syphilis: Congenital syphilis may simulate any phase of erythroblastosis, except the post-mortem findings. Several successive infants in one family may be affected. The history and Wassermann reaction of the mother are important, especially the infant's Wassermann and x-ray studies of its long bones, showing the sharply marked transverse lines at the ends of the diaphysis.

Congenital Heart Disease: Edema, dyspnea, cyanosis and cardiac hypertrophy would suggest congenital heart disease. Murmurs may or may not be present in this condition. The total red cell count is normal, or increased, while anemia and jaundice are not common. Heart failure may produce an enlarged liver and spleen. The nucleated red cell count has not been worked out in congenital heart disease. The subsequent course of events should enable one to differentiate rather clearly from erythroblastosis.

Intracranial Hemorrhage: This condition may actually occur during the course of erythroblastosis as part of the bleeding tendency. Uncomplicated intracranial hemorrhage does not exhibit edema, jaundice, enlarged liver or spleen, but the cyanosis, dyspnea and muscular twitchings of erythroblastosis do suggest intracranial hemorrhage. The spinal fluid in erythroblastosis is normal if there is no bleeding.

Hemorrhagic Disease of the Newborn: In erythroblastosis the degree of anemia is out of proportion to that which results from loss of blood in hemorrhagic disease, and the anemia appears later, for the disease usually does not exhibit itself before the third to sixth day of life. There is usually an absence of familial tendency in hemorrhagic disease. The blood picture shows no great change in the character of the red cells. Edema, severe jaundice, enlargement of liver and spleen should be absent. No doubt many cases of erythroblastosis in the past have been diagnosed hemorrhagic disease due to the bleeding that frequently accompanies icterus gravis.

TREATMENT

In the hydrops cases the babies die so quickly after birth that little experience has been gained in their treatment. Obviously the treatment indicated is immediate transfusion to correct the profound anemia that is present.

Transfusion is also the treatment of choice in the icterus gravis type of erythroblastosis as well as in the anemia phase. The former, however, requires the blood as soon as the diagnosis is made, followed by repeated transfusions, frequently and in small amounts usually 30-50 c.c. This immediately provides normal oxygen-carrying red blood cells to take the place of the patient's immature cells incapable of carrying the normal supply of oxygen. That it combats the moderate anemia is shown by the relief of cyanosis and dyspnea. It also allows or stimulates the baby's blood-forming system to mature its red blood cells before release into the blood stream. The number of transfusions necessary is variable, depending upon the rapidity with which the infant begins to manufacture its own mature red blood cells, as shown by daily counts. Four or five trans-

fusions are usually necessary, and one infant required as many as nineteen.

The blood may be taken from either parent as it is not necessary to type or cross-agglutinate in the case of the newborn. The baby's scalp vein or fontanelle should be used on account of the frequency with which the transfusions usually need to be done.

Fluids are forced by mouth and hypodermoclysis to the extent of 3-4 ounces per pound daily. Oxygen has been found to be of little or no value in the periods of cyanosis and respiratory distress. During the convalescent stage, or when the anemia is milder in type, the patient responds well to oral administration of about 4 grains of iron and ammonium citrate daily.

Given a mother who has had a succession of babies suspected of falling into one of the classifications of erythroblastosis, it would be interesting to interrupt the pregnancy at the beginning of the last month with the chance of obtaining an infant which, though premature, might perhaps be in an earlier stage of the process, and for that reason might be more amenable to treatment. It seems that by this means a living child might be gained for a family which had so far been unsuccessful due to the unfortunate familial tendency of this disease. Other methods of prenatal care such as keeping a patient in bed throughout pregnancy, feeding large doses of iron, and preventing toxemia have failed.

SUMMARY

1. A brief review of the literature is presented relative to universal edema of the newborn, icterus gravis neonatorum, anemia of the newborn, associated with erythroblastosis.

2. The findings characterizing each of the three distinct types are given, showing their similarity. This leads present workers in this field to the opinion that these types when considered as a group are closely related, that they represent a definite disease entity of the newborn, that the underlying cause whatever it may be is the same, inasmuch as they are dependent upon the same underlying pathological process.

3. The only method of treatment which

has been at all successful in the icterus gravis group has been repeated small transfusions. Interruption of pregnancy before term may save a few infants in the hydrops class if a familial repetition is known. Transfusion may be required in cases of congenital anemia.

4. To augment our knowledge of these syn-

dromes, a plea is made to both the obstetrician and pediatrician to increase their interest in the diagnosis and immediate treatment of erythroblastosis. We appeal, therefore, for post-mortem examinations to be made on more still-born infants, and on all neonatal deaths characterized by jaundice or hemorrhage.

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DISCUSSION

Dr. I. Newton Kugelmass (New York): Dr. White is rendering a service in the cause of the newborn. Recognition of relatively rare disturbances in terms of a definite disease entity is a mark of superior medicine. Birth injury is usually the basis for manifest disturbances *immediately after birth* for all others take several days to "incubate". To be on guard on the first day of life for anemia, edema and icterus in terms of one symptom-complex, erythroblastosis, is of decided clinical advance. This condition is promptly manifest at birth by striking symptoms. And these correlated with an enlarged spleen and liver and a history of loss of a previous baby at birth is a challenge for confirmation of erythroblastosis of the newborn.

Examination of the blood reveals a hyperchromic anemia of hemolytic origin; an enormous increase in the nucleated red cells, in the reticulocytes and in the bile pigment; an increase in the bleeding time, a decrease in the platelets and a normal clotting time; a normal resistance of the red cells. The hematopoietic system continues in the formation of embryonal red cells. Even the liver which normally ceases to function as a blood-forming organ persists in the production of red cells. The congenital defect in the development of the hematopoietic system is unrelated to any nutritional, endocrine or infectious origin. The condition is familial. And whatever starts the process brings about an abnormal red cell production and destruction resulting first in anemia. The consequent want of oxygen in utero increases the size of the placenta compensatively to supply more

oxygen. The destruction of the red cells by the reticulo-endothelial system likewise injures platelets. Obviously the severe jaundice and the hemorrhagic symptoms are secondary; and the edema is a consequence of diminished blood protein. The clinical and laboratory findings at birth depend upon how far the process has progressed. If early, the condition may be arrested; if late, extra-uterine life is impossible with a fetal blood picture.

I have seen two cases proved post-mortem. I have missed many because, as a pediatrician, I have not been called until the second or third day prior to exitus. Immediately after birth the rare condition of visceral hemorrhage may involve difficulty in differential diagnosis. But the treatment is exactly the same. *Intravenous transfusion* given promptly the first day, 50 to 80 c.c., and offered daily is most effective. This is correlated with intramuscular injections of liver extract. The baby is maintained under an oxygen tent for the anoxemia. The hydrating solution is administered every hour to combat shock. Breast milk or thick feeding is offered by Breck feeder.

The treatment attempted for erythroblastosis of the newborn is necessarily emergent. The saner approach is to treat the baby in utero if the condition occurred in previous newborns. All attempts at prenatal care have thus far failed. But other procedures should be devised from the first month of pregnancy based upon serial blood studies of the mother. We have already demonstrated the approach in the prenatal prevention of potential hemorrhagic disease.

CLINICAL CONTROL OF CHRONIC HEMORRHAGIC STATES IN CHILDHOOD

By I. NEWTON KUGELMASS, M.D., Ph.D., Sc.D., New York, N. Y.

Read before the Section on Pediatrics of the Medical Society of New Jersey at the Annual Meeting in Atlantic City, June 6, 1934.

Rational procedures for arresting hemorrhage are of ancient heritage. Homer relates with pride many of our current methods then applied to bleeding gods and fallen heroes of Greek mythology. While these methods were more effective for the inanimate gods than for human heroes, the same therapeutic attempts still remain routine. Hippocrates (400 B. C.) applied styptics, ice, compression and elevation with better reasoning than result in the treatment of bleeding wounds. Celsus (20 A. D.) introduced cauterization, excision and ligature as surgical means of treating hemorrhage. But these procedures were only used in emergencies because bleeding was considered an earthly means of bodily purification. Local measures of treating hemorrhage persisted until the 19th century when Blundell (1824) first transfused man from a human donor. Thus did two centuries pass before the therapeutic value of transfusion was turned from the metaphysical speculation of rejuvenation to rational physiology. It was not until 1860 when Alexander Schmidt studied the mechanism of blood coagulation that new approaches developed in the diagnosis and treatment of hemorrhagic disturbances.

Hemorrhagic states are unitary and unique. Their manifestations are as individual as the particular patient, as varied as the determining disease, and as widespread as are the offended organs and tissues. And yet they show few symptoms and fewer signs to be ever adequate for diagnostic differentiation without further scientific study. The more accustomed we are to seeking similarities in the diagnosis of disease, the more are we eluded in attempts at patterning pictures of hemorrhagic diversities. The hemorrhagic state is a many dimensional portrait rather than a two-dimensional textbook picture. Confronted with a hemorrhagic problem we must neither confuse the site nor severity of bleeding with a specific hemorrhagic

state. In no field of medicine is clinical judgment more exacting than in the interpretation of hematological findings. Yet effective control of hemorrhagic states—potential or active—depends upon simple therapeutic measures once diagnostic specificity has been determined.

Hematological studies of children presenting hemorrhagic symptoms have greatly minimized the number of true hemorrhagic diseases. In a sequential series of 5000 sick children observed in three hospitals in the city, 7 per cent showed hemorrhagic symptomatology. But out of the 325 cases involving bleeding symptoms, only ninety-five proved to be veritable hemorrhagic diseases with abnormal deviations in the blood clotting constituents. While these children showed more marked and more persistent bleeding than those with non-hemorrhagic diseases, the sites of bleeding were no different. Localized hemorrhages were more frequently the results of systemic disease than of local injury. And marked multiple hemorrhages usually revealed active hemorrhagic disease. Spontaneous bleeding was more prevalent than the traumatic and more difficult to control. In newborns it was the consequence of non-hemorrhage disease, while in children spontaneous bleeding was precipitated by active hemorrhagic disease. Bleeding symptoms predominated among boys with true hemorrhagic diseases and among girls with non-hemorrhagic diseases and a family history of a bleeding tendency was obtained in both groups. The majority of hemorrhagic problems was observed in older children, but more effective control of hemorrhage was obtained in younger children in whom mild bleeding manifestations resulted in early hematological diagnosis. And yet we have witnessed recovery from very severe injury to the reticulo-endothelial system at all ages. The more hemorrhagic problems we study, the more atypical and transitional they behave in

comparison with classical descriptions. Hemorrhagic states ever require individual study for diagnostic certainty.

ESSENTIAL DIAGNOSTIC PROCEDURES FOR HEMORRHAGIC DISTURBANCES

Hemorrhagic symptomatology rarely reveals the clinical diagnosis. Methods have been devised for the study of the actual changes in the blood and the vessels to determine the mechanism of these disturbances. Changes in the behavior of *blood* and in the concentration of its constituents are the result of essential *hemorrhagic* diseases; while changes in the functional behavior and structural integrity of the *blood vessels* are the result of *non-hemorrhagic* diseases. In the former the defect determining the hemorrhagic disease is actually within the blood, reflecting, of course, abnormalities in the reticulo-endothelial system. In the later the defect is in the vascular wall without any disturbance in the blood.

Whatever the clinical impression of the type of hemorrhagic disturbance, every child requires a complete blood study including the hemoglobin content, the red cell, the white cell, and the differential counts. This rules out at once the presence of leukemic processes, a bone marrow and splenic diseases. Then the determination of the clotting time, the clot retraction time, the bleeding time, the platelet count, and the degree of platelet stability all indicate the type of change involved in the blood. If the results of these procedures are normal, it is further necessary to determine the content of the blood clotting constituents, fibrinogen, prothrombin, and antithrombin. Finally the tourniquet test is applied, the capillary nail beds are examined microscopically, and the fluid output measured to determine the presence of vascular dysfunction. No single procedure is ever diagnostic of hemorrhagic disease, for it takes the correlation of all these determinations with the family history, their hemorrhagic tendencies, the child's previous hemorrhagic history, and the present clinical findings to establish the diagnosis.

A NEW CLASSIFICATION OF HEMORRHAGIC STATES

Modern diagnostic procedures correlated with the clinical manifestations of hemorrhagic disturbances necessarily lead to a well-defined classification. The disease entities that produce changes in blood-clotting substances constitute one group of hemorrhagic diseases, while those that produce changes in the vascular endothelium constitute another group of so-called non-hemorrhagic diseases. Although vascular injury is present in all hemorrhages, yet it is not the determining factor in the disease process when the blood constituents are actually altered. Every hemorrhagic state involves a controlling factor in the blood; or in the vascular dysfunctions there are acquired and hereditary diseases. If the prothrombin be deficient in the newborn, hemorrhagic disease precipitates. If the platelets be diminished, we have a thrombocytopenic purpura. If fibrinogen be deficient, hemorrhagic diseases of the liver result. If any of these blood clotting constituents be either defective or deficient from infancy, we have the respective familial diseases.

On the other hand, if the vascular endothelium suffers from malnutrition, scurvy or marasmus, with normal blood pictures in the clotting constituents.* Likewise, if the capillaries be injured by allergens, allergic purpura is the result. Again vascular injury may be produced by chronic infections and chemical poisons with resultant hemorrhagic symptoms. And besides these types of vascular injury one may inherit actual defectiveness in the capillary structures and thus suffer from a *familial* disease. Each of these diseases originating in the blood or in the capillaries is amenable to control to the extent that the deficient or injured factor is replaced or regenerated therapeutically. The control of the essential hemorrhagic diseases or the non-hemorrhagic diseases depends upon the proper classification of the disturbance. Once the mechanism of the bleeding symptoms is understood, the therapy indicated either corrects the deficient blood clotting constituents or decreases the vascular permeability. The chronicity of hemorrhagic disturbances necessitates continuous clinical

supervision in the prevention of recurrent hemorrhagic episodes.

DIETARY CONTROL OF CHRONIC HYPOTHROMBINEMIA

A bleeding tendency is not infrequently observed as a persistent manifestation of apparently well children. They are undernourished for their body build, and are not derived from hemophilic families. Usually the bleeding symptoms are trivial and only presented as a complaint incidental to an irrelevant acute illness. Epistaxis and easy bruising are outstanding symptoms, although other bleeding disturbances may occur. Physical examination is usually negative, and the clotting time is prolonged or even normal; but determination of the clotting constituents reveals a decreased content of prothrombin or fibrinogen content of the blood. The antithrombin concentration is usually increased, but the platelets are normal in both quality and quantity. We have observed no evidence that the vascular endothelium is at all affected as judged from the tourniquet test and microscopic examination of the capillary nail beds.

Such benign bleeding manifestations are evidences of nutritional deficiency. The outstanding factor common to all is a hypothyrombinemia. Both prothrombin and fibrinogen are derived from the liver. Their decrease in these cases is not a result of impaired liver function but rather the consequence of protein deficiency. Prothrombin is a protein substance which we have observed to increase in the blood following high protein diets. A further consequence is a subsequent diminution of the bleeding symptoms. The associated anemia in these undernourished children is unrelated to the bleeding symptomatology. The anemia observed is a result of nutritional deficiency.

The prevalent notion that hemorrhage follows anemia is unfounded. We do not observe bleeding in acute or chronic anemia even when the hemoglobin is as low as ten per cent, and the red cells drop to one million. Never does hemorrhage occur in severe chlorosis or in any of the anemias unless there be bone marrow injury. Such is not the case in these children with mild recurrent bleeding following trauma.

Furthermore, there is no evidence of hemorrhage in the severest hydremias. Then the blood proteins are reduced to one-third their normal level, which produces no disturbance of the nutrition of the vascular endothelium. The basis for the hemorrhagic tendency in the group of children here presented is a diminished prothrombin or fibrinogen content of the blood, corrected within two weeks by the administration of a high protein diet. We have observed a hypothyrombinemia in a group of boys who were referred to us as possible hemophiliacs. Thus has our "clotting diet" become effective in the control of a chronic hemorrhagic condition confused with hereditary hemophilia.

TREATMENT OF TYPES OF THROMBOCYTOPENIC PURPURA

Purpura is the most universal of hemorrhagic symptoms. The patches may characterize a well-defined disease entity of the reticulo-endothelial system, or be a symptomatic manifestation of bone marrow diseases, splenic diseases, leukemic processes, infectious invasions, chemical injuries, or allergic offences. The essential purpuras resulting from reticulo-endothelial disease are particularly amenable to treatment once the diagnosis has been determined and their mechanism mastered. Essential thrombocytopenic purpura is precipitated abruptly with bleeding from the mucous membranes and into the skin as purpuric eruptions.

The blood shows a marked diminution of the platelets, a leucocytosis, a post-hemorrhagic anemia with evidence of erythropoiesis, a normal or slightly delayed clotting time, a prolonged bleeding time, a non-retractile clot and a marked capillary resistance test. While this blood picture is characteristic, the clinical findings are variant in so far as they have specific bearing upon the purpuric mechanisms. It is in the interpretation of the physical findings that the type of essential purpura may be determined as a basis for effective treatment. The following cases are illustrative of our approach in the control of purpuric disturbances:

a. Correcting Nutritional Deficiency.

Dr. Marton's boy developed petechiae over the gums and palate, and bled from a loosened tooth

at seven years of age. Recurrent nose bleeds and purpuric spots throughout the body continued over a year. Periodic examination of his blood picture by several physicians confirmed the diagnosis of thrombocytopenic purpura.

He came under my observation at the age of eight when I found his nutritional history most significant. A markedly allergic boy with chronic eczema, he was quantitatively deprived of protein and fat. His blood picture showed a hemoglobin of 65 per cent, red blood cells 3.8, white blood cells 12,000, platelets 40,000, bleeding time 16 minutes, clotting time 3 minutes. Medical consensus was for splenectomy as a last resort. A high fat and protein diet alone brought the platelets from a further drop to 20,000 to 400,000, with complete disappearance of purpura since 1927.

Typical thrombocytopenic purpura was cleared in this boy by nutritional therapy. The basis for this approach was a careful study of the nutritional history as part of a clinical picture. Dietary fat deficiency correlated with the lipid nature of platelets led us to this treatment. We have found high protein and fat diets in our so-called "clotting dietary" effective under similar conditions of dietary fat deficiency. One boy of four developed a mild thrombocytopenic purpura persisting for six months when a clotting dietary cleared the condition without further treatment. He was deprived of fat for over two years because of a chronic celiac condition. Another child similarly treated developed purpura in the course of cyclic vomiting. The replacement of fat in the dietary brought prompt recovery from purpura.

Prolonged nutritional deprivation of the gross constituents in the dietary, such as protein and fat, does not always produce deficiency disease. Much of the symptomatology resulting from one-sided dietaries, therapeutic or habitual, must be promptly corrected once hemorrhagic manifestations appear. And not infrequently such simple dietary procedures alleviate apparently alarming conditions.

b. Eliminating Infectious Foci.

D. T., a six-year girl, suddenly developed nose bleeds, hematuria and petechiae over the extremities following a severe upper respiratory infection. The child was undernourished for her body build, the tonsils were diseased, the spleen two cms. below the costal border. X-ray examination of the sinuses was negative. The Hgb. 50 per cent; R.B.C. 3.4; platelets 55,000; clot retraction delayed; tourniquet test positive; bleeding time 18 minutes; clotting time 3 minutes. Repeated transfusions

and subsequent tonsillectomy cleared the purpura. Although the blood picture became normal and the platelets rose to 200,000, the tourniquet test persisted positive and the child developed black and blue spots following trauma.

Infection not infrequently suppresses bone marrow activity or more usually injures capillary endothelium. This case is illustrative of the destructive effect of the streptococcus toxin upon the megakaryocytes as well as of vascular injury. The only obvious related primary focus was the diseased tonsils. Their removal cleared the condition. But the residuum of easy bruising indicates that only part of the infectious focus was eliminated. Once systematic manifestations of an obvious infection appear there result simultaneous multiple foci, difficult if not impossible to eliminate. We are thus confronted with loci rather than foci of infection to be eliminated in the treatment of purpura. But the early establishment of causative relationship of such foci should lead to their prompt eradication if control of the purpura be the consequence.

Dr. Wohnus' Child: A ten-year girl first developed purpuric spots over the left knee only to be followed by profuse crops throughout the entire body on the following day. Then there were profuse nose bleeds, blood vomitus confluent facial hematomas, tarry stools and vaginal bleeding. The diagnosis of acute thrombocytopenic purpura was confirmed by several attending physicians. Repeated transfusions tided the child over this severe attack. Purpuric manifestations recurred following short remissions for over a year. Then the child came under my observation. The Hgb. 75 per cent; R.B.C. 4,000,000; W.B.C. 12,200; P. 70 per cent; platelets 60,000; bleeding time 18 minutes; clotting time 3 minutes; tourniquet test positive; clot retraction deficient. The child showed clinical and roentgenographic evidence of chronic sinusitis. She was promptly immunized against the hemolytic streptococcus obtained from the sinus washings. The child has been free from purpura for over one year.

Infectious etiology in purpura is widespread. It becomes of determining significance in the treatment of purpura. If the infection be self-limited, all forms of therapy directed at the symptomatic purpura will be of transient avail until the infectious process has passed. Then must residual foci be eliminated if chronic purpura is to be prevented. But if the infectious invasion be non-apparent in the face of dramatic purpuric bleeding, concentrated effort must

needs be directed for its isolation. Then and only then can specific therapy against that infection halt hemorrhagic happenings.

I have studied a child admitted with precipitate purpura following several months bleeding from the gums. The blood picture was characteristic of thrombocytopenic purpura with platelets to 40,000. But the purpura did not clear until specific systemic therapy was administered against the causative Vincent's infection. I have seen thrombocytopenic purpura complicating pneumonia in a five months' infant. There were severe hemorrhagic symptoms, marked anemia, platelet count varying between 60,000 and 90,000 and bleeding time from ten minutes to one hour. The purpuric picture persisted for one month simultaneously with otitis media as a focus despite recovery from the pneumonic process. Repeated transfusions with careful supervision of the offending otitis media eliminated the purpura. I have also observed a course of thrombocytopenic purpura complicating malignant diphtheria, congenital syphilis, miliary tuberculosis and sepsis respectively. Treatment in these severe infections was necessarily directed at the infectious agents for the purpura persisted throughout the duration of these infections.

c. Regulating Ovarian Function

T. S., a girl of thirteen, suddenly developed purpuric spots over the extremities. The onset of the bleeding symptoms was simultaneous with that of the first menstruation at twelve and one-half years. Then there was not only an excessive loss of blood but as well bleeding gums and easy bruising, which recurred with each menstruation. The Hgb. 65 per cent; R.B.C. 4,000,000; W.B.C. 9200; polys 68 per cent; lymphs 20 per cent; platelets 96,000; bleeding time 10 minutes; clotting time 12 minutes. Treatment with active ovarian extract gradually diminished the recurrence of severe menstrual purpura so that all hemorrhagic symptoms were finally eliminated by the fifth month.

Ovarian dysfunction not infrequently accounts for the genesis of thrombopenia. Such relationship is very striking in the clinical cases thus far observed in that purpura recurs with each menstrual cycle. The mechanism of hormonal effect upon suppression of bone marrow is unknown. But the diminution of platelets during menstruation, the increased capillary permeability with ovarian deficiency, the preponderance of thrombopenia in females are

facts in favor of the administration of ovarian therapy in such cases.

d. Indications for Splenectomy.

J. W., a fifteen-year boy, suddenly collapsed bleeding for the first time from the nose, jaws and pharynx. Then appeared petechiae over the mucous membranes and crops of purpuric spots over the chest, pelvis and extremities. The physical examination showed nutritional dystrophy, moderate lymphadenitis and an enlarged spleen. The Hgb. 40 per cent; R.B.C. 2.5; W.B.C. 3.2; polys. 24; lymphs. 70 per cent; reticulocytes 0.2 per cent; platelets 25,000; clotting time 8 minutes; bleeding time 18 minutes; clot retraction zero; tourniquet test positive. Hemorrhage became uncontrollable and transfusions were of little avail. Although the medical diagnosis was aplastic anemia the surgical consensus was for splenectomy. This blood picture reveals a symptomatic cytopenia associated with marked reduction in the white cells and granulocytes as well as with an absence of all signs of regeneration of hemoglobin and the red cells. Besides there was no evidence of increased destruction and red cells in stained smears, no fragmentation of red cells and the icteric index was low.

PURPURA

Splenectomy is not a specific in the control of hemorrhage. Its effectiveness is limited to essential thrombocytopenic purpura and several other diseases with similar mechanism wherein primary splenic disease affects bone marrow function. This necessarily excludes primary leukemic processes and bone marrow diseases. Even in the limited number of cases in which splenectomy is indicated it is as yet not altogether possible to determine pre-operatively in which this operation is the procedure of choice. The case cited is illustrative of when splenectomy should not be performed. Surgical specificity is life saving in emergencies but misapplied operative intervention interferes with the prognosis and with progress. Splenectomy is contraindicated if the blood picture suggests a deficient production of blood elements other than the platelets. Therapeutic splenectomy is out of the question if the hemoglobin and red cells show more marked reductions than simple hemorrhage would produce, if there is a marked leukopenia particularly in the granulocytes and finally if in the presence of these reductions in the blood elements there is no evidence of active hematopoiesis. Mere reduction in platelets is never an indication for splenectomy. Every medical effort must be made for complete correlation

of all the blood findings with the clinical picture before yielding to splenectomy.

M. T., four-year girl, showed recurrent purpuric spots over face and chest for two years. With each crop there was simultaneous bleeding from gums, nose and throat. A loosened tooth bled continuously for two days requiring hospitalization. The physical examination was negative and even the spleen was not palpable. The Hgb. 60 per cent; R.B.C. 3,000,000; W.B.C. 12,000; platelets 30,000; bleeding time 15 minutes; clotting time 3 minutes; clot retraction zero; tourniquet test positive. Splenectomy was performed following repeated transfusions. All hemorrhages stopped and within twenty-four hours platelets rose to 200,000. One week after operation the platelets were 350,000, second week 500,000, third week 700,000; the blood picture became normal.

Such is the intermittent course to chronic thrombocytopenic purpura. Remissions may last a few weeks or continue for months or even years with the platelets at low levels. When they fluctuate about the danger zone bleeding is imminent. With the purpuric process continuous the blood picture is abnormal even though the clinical manifestations are not always apparent. When bleeding does occur the blood picture frequently shows a relative lymphocytosis which may confuse with lymphatic leukemia. A polymorph preponderance in purpura is indeed the more favorable index of bone marrow activity.

Treatment is directed at methods of raising the platelets content of the blood. Transfusions arrest bleeding not only because they contribute tremendous numbers of platelets, but particularly because they stimulate bone marrow activity. Mere addition of platelets is transient because of their four-day duration. Caution must be exercised in the transfusion of purpuric children because of their great susceptibility to shock of an already injured reticulo-endothelial mechanism. Therefore, accurate typing and matching must not be foregone even in emergency transfusion. Under such circumstances it is preferable to tide the patient over with intramuscular blood in the interim of selecting a suitable donor. Even non-specific protein therapy is effective in the early stages of the disease in that it induces marked rises in platelets and decreases capillary permeability.

But platelet reduction in purpura is not alto-

gether responsible for bleeding. We have seen extreme thrombopenia without hemorrhages, as well as the converse condition indicating effort on the capillary walls as well as on the platelet mechanism. Therefore, it is necessary in the treatment of purpuric bleeding not only to increase the platelet level of the blood but as well to decrease the capillary permeability. This may be accomplished by the intravenous administration of 10-25 c.c. of 10 per cent calcium gluconate. This procedure may be reinforced by the oral administration of calcium salts. Local bleeding from mucous membranes may be arrested by applying dressings of Kephirin, a stable intermediate of epinephrin. Thromboplastic agents are quite ineffective locally and systemically.

But the chronicity of essential purpura may be cured by splenectomy. It is safe when properly timed and effective when indications are clear cut. Chronic cases may show a persistent mild leukopenia indicating some exhaustion of the bone marrow as well as anemia resulting from the loss of blood. Both of these conditions are indications for splenectomy provided there is evidence of active hematopoiesis. If bleeding be controlled by medical measures and there be a persistent leukocytosis, the bone marrow is reacting and so it is preferable to continue to control the problem without splenectomy. In acute purpura splenectomy may be a life-saving measure provided preliminary large transfusions are given daily to bring the hemoglobin and red blood cells to a favorable level. In such acute emergencies the platelet level is of no factor in surgical prognosis. Splenectomy is the procedure of choice when transfusions fail to arrest bleeding in a child that is afebrile, whose blood shows active regeneration and whose general condition after transfusion indicates fair surgical risk. Purpuric bleeding is promptly arrested after ligation of the splenic vein and no bleeding continues during or after splenectomy. But every child who leaves the operating room in good condition requires continuous medical supervision. Not infrequently shock suddenly follows splenectomy. It may be immediate or delayed, hence a donor should be on hand for an emergency transfusion to combat post-operative collapse.

Clinical cure is not always complete following splenectomy. The more clearly the blood picture conforms to the characteristics of the essential type of thrombocytopenic purpura, the better the end result. The spleen in this type of purpura inhibits the production of platelets by the bone marrow. More specifically deranged splenic function results in defective separation of the platelets from normal megakaryocytes. Therefore, removal of the spleen produces a rapid and persistent rise of platelets to levels beyond the normal range for years following operation. But in the type of thrombocytopenic purpura in which there is a deficient production of megakaryocytes by the bone marrow the removal of the spleen is less beneficial if not unnecessary. It is this type of purpura that is less difficult if not impossible to differentiate pre-operatively unless the blood picture reveals semblances of aplastic anemia. Post-operatively we see a transient rise in platelets with an apparent clinical cure but subsequently they fall again to low levels when hemorrhages recur. The return of purpuric symptoms has also been attributed to residual accessory spleens, fairly common in children. Their presence following splenectomy thus furnished a source of inhibition of platelet production. Therefore, there is dual responsibility medically to differentiate the type of essential purpura that will respond to splenectomy and surgically to the complete removal of all splenic tissue.

EVALUATING SYMPTOMATIC THROMBOCYTOPENIC PURPURA

Purpuric symptoms associated with diminished blood platelets occur in the course of many diseases. Exceptionally do they characterize the essential form of purpura. They are consequences of acute infectious diseases, of sepsis, of chemical injury, of primary blood diseases and of conditions in which the bone marrow is replaced by other tissues as in Gaucher's disease, Niemann-Pick disease, osteosclerosis, marble bones and a variety of milder toxic disturbances characterized by a reduction in the circulatory myeloid elements of the blood, such as: agranulocytosis, aplastic anemia, aleukia hemorrhagica, etc. The throm-

bocytopenic purpura, therefore, represents but one of several destructive processes in the parenchyma of the bone marrow. The injury of the megakaryocytes diminishes platelet formation just as injury to other parts of the bone marrow produces comparable changes in the blood cells. Obviously this specific treatment in the selective injury to the megakaryocytes does not apply to more extensive injury to the bone marrow. The treatment of symptomatic thrombocytopenic purpura depends wholly on the nature of the primary disease.

VASCULAR HEMORRHAGIC DISEASES

Hemorrhagic symptoms abound in disturbances of the vascular channels. Their integrity may be altered structurally or functionally with consequent escape of normal blood. Vascular structure may be affected externally by trauma, and internally by increased pressure, by lack of nutritional elements, by bacterial invasion, by chemical injury, and by lymphatic infiltration. Occasionally one is born with defective vascular structure in one part of the body or another. Again vascular function may be influenced by internal secretions, by allergic substances and by infectious agents. Although structural changes necessarily disturb vascular function, the one group of hemorrhagic disturbances may be differentiated from the blood etiologically on the basis of extravasation of blood on the one hand and blood combined with exudative inflammatory changes on the other. Such clinical differentiation offers direct therapy on the basis of the etiological factor interfering with vascular integrity.

The methods of studying the status of the child's vascular endothelium are as yet very crude, but clinically accurate. Diminished capillary resistance may be determined by the tourniquet test yielding petechiae, or hemorrhages; or it may be gleaned from the diminished urinary output in the erect posture in the presence of capillary pathology. It may be observed microscopically from capillary nail beds revealing structural changes. But our determination of the presence of vascular pathology is made indirectly when blood studies show normal content of clotting constituents. Thus are the vascular problems, strictly speaking, non-hemorrhagic diseases.

1. HEMORRHAGIC AVITAMINOSIS

R. N., a four-month female infant, was admitted for treatment of nutritional atrophy. Born at full term of an emaciated mother, the baby was maintained on very dilute boiled milk mixtures at irregular intervals with indiscriminate care. After gradual adjustment of concentrated feedings the baby nevertheless failed to thrive. There were no evidences of enteral and parenteral infection. Blood Wassermann tests and radiographs of the long bones were negative. Petechiae first observed in the mucous membranes spread until purpuric spots covered the body. The blood picture before transfusion showed Hgb. 70 per cent; R.B.C. 3.8; W.B.C. 14,000; lymphs. 55 per cent; platelets 180,000; tourniquet test positive; clotting index 0.45. The purpura was unaffected by transfusion but cleared gradually with vitamins A, B, C, and D, reinforcing the feeding regime. Vitamin deficiency produces capillary degeneration. In this case nutritional deficiency preceded birth and was particularly striking in the paucity of these vitamin factors in both mother's and baby's food. The blood showed no evidence of hemorrhagic disease but the purpura was a result of vascular injury resulting from vitamin deficiency.

Scurvy is a classic example of the specific relation of vitamin C to hemorrhage. The primary disturbance is a separation of the cement substances binding the vascular endothelium cells. It is only in severe cases that bone marrow atrophy is produced with subsequent diminution in platelet formation. In children the external vascular phenomena bespeak the typical clinical picture. And their manifestations are latent and elusive early in the deprivation of vitamin C in the dietary. But so much emphasis has been placed on the rôle of vitamin C in the vascular hemorrhage that others have been neglected. Fanconi demonstrated hemorrhagic symptoms in children with Herter's infantilism to be a consequence of vitamin deprivation. Others have observed similar phenomena in the course of marasmus. Apparently the nutrition of the vascular endothelium depends largely upon the vitamin adequacy of the dietary.

2. ALLERGIC PURPURA

A. L., a five-year boy, had recurrent attacks of colic since infancy. They usually occurred during the spring with pain in the abdomen and musculature followed by tarry stools with mucus. All treatment was refractory, each episode being self-limited. At the fourth year the attack was so severe that the appendix was removed. When he came under my observation during an attack the boy showed infected tonsils, carious teeth, intense dermatographia. The Hgb. 80 per cent; R.B.C. 3.8;

W.B.C. 17,000; platelets 270,000; clotting time 5 min.; bleeding time 4 min.; tourniquet test positive; polys. 745; eos'n. 5 per cent. Urine showed albumin, casts and red blood cells. Parents both allergic. The removal of carious teeth, tonsillectomy and gradual desensitization with a non-hemolytic streptococcus obtained from culture of tonsils have prevented these attacks thus far for two years.

Systemic hemorrhagic attacks recurring in allergic children are well defined syndromes. The tissues affected by hemorrhage have previously been differentiated as separate syndromes, gastro-intestinal hemorrhages as Henoch's Purpura, joint involvement as Schoenlein's Purpura, cutaneous eruptions as Erythema multiforma. But the advent of the allergic mechanism has unified these syndromes into a single group of allergic purpura. They are usually the result of bacterial, food or drug allergy in children of allergic constitution and parentage. The purpuric eruptions usually follow generalized symptoms which together constitute the recurring pattern for the particular child. The blood clotting function is normal but the capillary resistance is varied in the same patient. Once the diagnosis is determined, recovery is spontaneous and prognosis is always favorable.

But the prevention of recurrent allergic purpura requires the discovery of the specific allergic offense. In the case of Henoch's Purpura cited the elimination of the oral foci of infection cleared the condition. In another case of a five-year girl purpuric spots appeared over the legs with each attack of tonsillitis. Tonsillectomy was performed on the basis of a supposedly rheumatic fever and post-operatively petechiae and joint pains recurred. When the child was first presented, a diagnosis of Schoenlein's Purpura was made. The persistence of a hemolytic streptococcus in the sinuses was the focus responsible for the exacerbations. Desensitization with a specific vaccine eliminated the allergic purpura. Another girl of eight showed recurrent attacks of abdominal cramps, joint pains and purpuric spots over the legs for two years. Since there were no foci of infection, skin tests were made. On that basis, wheat, egg yolk and pork were eliminated with complete disappearance of symptoms except the pur-

puric eruptions. Accidental inclusion of an egg-containing food precipitated allergic symptoms. Clinical variations of allergic purpura are innumerable. Recurrent attacks are treated for indigestion, rheumatic fever, purpura, sepsis and operated upon for appendicitis, intussusception or gastric ulcer before the actual diagnosis is established. But the attacks continue until the allergic offense is eliminated.

3. HEMORRHAGIC INFECTIONS

H. R., a boy aged four years, was admitted to the hospital with a history of convulsions associated with a severe infection of the upper respiratory tract. Hemorrhage appeared in the orbit and marked purpuric extravasations over the trunk and upper extremities. Facial weakness and complete right hemiplegia followed. Examination of the blood showed: clotting and bleeding times, normal; tourniquet test positive; platelets 310,000; platelet lysis 35 per cent; and blood clotting function normal. An encephalitic infection was the cause of the purpura.

Hemorrhagic symptoms predominate in infectious invasion. Vascular injury usually exceeds the disturbances in myeloid function, but the relative changes in each depend on the severity of the infection. I have observed as confirmation of vascular injury petechiae containing the organisms of meningococcemia, embolic abscesses with visceral hemorrhages in pneumococcemia, nose-bleeds, and even hemorrhagic sputum in epidemic influenza, thrombotic petechiae consisting of tuberculids, punctate hemorrhages in scarlet fever, bleeding of the mucous membranes in diphtheria, hemorrhages from the mucous membranes in congenital syphilis and purpura associated with the presence of endothelial cells in circulating blood of subacute bacterial endocarditis.

Capillary hemorrhages are not infrequent as consequences of vascular congestion in the course of chronic infections. Rheumatic heart disease induces epistaxis or congestion hemorrhages in the lower edematous extremities. Pertussis precipitates hemorrhages into the conjunctivae and eyelids as well as from the nose and bronchi. Uremia occasionally reveals terminal cerebral, retinal and intestinal hemorrhages rather than petechiae. The hemorrhagic symptoms in uremia parallel the severity of capillary damage from infection and not the degree of nitrogenous retention. Increased

venous pressure in normal circulatory systems is not a determining factor in the bleeding manifestations.

Arrest of bleeding in the course of infectious invasion may be brought about by therapeutic measures for decreasing capillary permeability. Elimination of infection is, of course, the primary concern, but the self-limited nature of infectious disease necessarily requires vascular medicaments. Clinically, calcium salts have been used in most hemorrhagic diseases for centuries, with favorable effects but based on erroneous interpretations. The calcium required in the clotting mechanism is rarely found wanting in amount necessary for this process. Even the striking clinical entities involving hypocalcemia never reveal bleeding symptoms.

Calcium therapy is indicated in abnormal bleeding resulting from vascular dysfunction. Its effect is specific in decreasing capillary permeability. The calcium salts administered have no bearing whatever on elevating the well-buffered calcium content of the blood. Calcium therapy is best administered intravenously in a 10 per cent solution of calcium gluconate or calcium chloride, from 10 to 25 c.c. injected very slowly. Oral administration is of course, slower in its effect, but may well be supplemented in from 5 to 10 grain (0.33 to 0.65 Gm.) doses offered between feedings to prevent its precipitation into the intestinal tract and subsequent loss in the stools.

The administration of gelatin arrests bleeding by condensing platelets on the vascular beds. It may be injected intravenously in 10 per cent solution from 20 to 40 c.c. or fed in 10 per cent solution either directly, sweetened and flavored with vanilla, mixed with milk or as a jelly, which may be kept on ice for two days.

Solution of pituitary is an effective vasoconstrictor in arresting bleeding. This mechanism is operative in vascular beds other than those of the female genital organs. The injection of 0.5 c.c. of pituitary frequently suffices to arrest capillary oozing when due to vascular injury. The action is more prolonged than that of epinephrine hydrochloride. It is the vasopressor fraction of the posterior lobe

that affects the vascular endothelium in the direction of increased blood coagulation.

HEREDITARY HEMORRHAGIC DISEASES

Hemorrhagic tendencies may be truly in-born. They are the consequence of hereditary defectiveness rather than symptoms of disease. In no other ailments is the medical history of previous generations as significant as in the transmission of hemorrhagic defectiveness. And its manifestations are so dramatic as never to be forgotten by any family. Teleologically there exist geno-types with transmitted defects in the formation of each of the clotting factors, sex-linked defectiveness in platelets in hemophilia, familial abnormalities in platelets in thrombopenia, congenital derangement in fibrogen formation in fibropenia, familial defectiveness in vascular channels in telangiectases. Thus may each of the factors involved in the clotting mechanism be formed defectively throughout life as a family failing. But these constitutional familial hereditary diseases are not always clear cut for nature's defects are never selective. Obviously combinations of hemorrhagic defectiveness exist as pheno-types of the well-defined hereditary diseases. Clinically, even hereditary diseases are the result of disturbances existing simultaneously in the bone marrow, spleen, liver and capillaries. Therefore, all the more caution in the diagnostic finality of hereditary hemorrhagic tendencies.

1. HEREDITARY HEMOPHILIA

A. H., an eight-year boy, bled from infancy with every disturbance. The mother's oldest brother was a bleeder. Continuous bruising followed slight trauma since walking. A large hematoma of the leg followed an insect bite. An abrasion of the lip oozed for ten days. A slight laceration of the hand from cut glass upon falling bled for days in spite of the administration of tetanus antitoxin. But a transfusion from the mother promptly arrested the bleeding. Hemorrhagic effusions into the left knee joint recurred until whole blood was administered from the mother at her menstrual period. Bruises continued following trauma but bleeding ceased after fortnightly injections of ovarian extract intramuscularly and goat's serum intradermally.

Hemophilic bleeding can be controlled, but not cured. Mild bleeding may be stopped locally by application of fresh raw meat, fresh blood, or cephalin after the removal of useless

clots. Pressure alone is contraindicated. All other hemostatics locally applied are ineffective. Severe bleeding may be checked for four days by the transfusion of whole blood from a suitable donor. Even an ounce of injected blood arrests hemorrhage, but the degree of subsequent improvement depends on the amount of blood given. Stored serum is ineffective in inhibiting clotting, but an ounce of fresh serum arrests bleeding within a day.

Hemophilia is as characteristic clinically as it is hematologically. It occurs in the male with a typical familial bleeding pattern. It is transmitted by the female although the mother's blood shows a normal blood clotting function. Bleeding is protracted, the clotting time is prolonged; and paradoxically the bleeding time is normal. Hemophilic blood shows the lowest index of blood clotting function, and a normal or increased number of platelets, physiologically defective because of their striking stability. Capillary resistance tests reveal no impaired function.

Bleeding from superficial injuries may be diminished by passive sensitization. The maintenance of an allergic state by repeated serum therapy increases the prothrombin sufficiently to be protective of capillary hemorrhage following trauma. In fact, the clotting time of capillary blood is diminished within two hours of the injection of serum. But the change produced in the blood is inadequate against injuries involving the larger vessels and joints. The child is sensitized preferably to goat's serum by subcutaneous injection of three c.c. At the end to a fortnight the child is given from two to three minims of the serum intradermally. The appearance of a wheal at the site of injection indicates passive sensitization. The intradermal injection of the same serum should be repeated every two weeks for the maintenance of the allergic state. Another procedure effective in arresting hemorrhage in emergency is a transfusion of blood from a donor sensitized to goat's serum. The intradermal injection is repeated every fourteen days to continue sensitivity in the hemophilia.

Bleeding into the joints may be controlled by *ovarian hormone* therapy. Most hemophilies bleed from the mucous membrane of the nose,

mouth and gums and into the joints. Other sites of hemorrhage are relatively infrequent in comparison. And no form of therapy thus far advanced has been effective as the injection of female sex hormone. Its absence in the blood of tissues of hemophilic boys is an hereditary sex link deficiency factor. Its administration weekly produces no change in the concentration of clotting substances but rather upon decreasing capillary permeability. Injection of active ovarian extract is indicated for interim treatment of the hemophilic state rather than control of acute hemorrhages. Repeated intramuscular injections decrease the bleeding tendency without affecting the easy bruising. Acute joint lesions require splinting and even immobile plaster of paris bandages until pain disappears and the hemorrhage absorbed. Aspirations are contraindicated. Chronic hemophilic arthritis requires correction of deformities. Traction or wedging plasters or mechanical appliances stretch the contracted tissue and strengthen the joint. Then the limb is kept in the corrected position by elastic bandage.

The prevention of hemophilia is a problem for *eugenics*. The course of the disease can be altered. Nature spares hemophilic newborn infants from the effects of birth trauma by the transmission of an abundance of female sex hormone into the infant's circulation. Thus is it that the disease does not become manifest until late in infancy, unless surgical intervention precipitates bleeding. The disease tends to ameliorate with growth, particularly after the endocrine adjustment of puberty. The avoidance of trauma by limitation of activity requires compensatory physical therapy to improve muscle tone. The maintenance of bodily warmth and vacations in warm climates appear, in addition, to alter favorably the course of the disease. The clotting dietary has produced no appreciable effect on the hemorrhagic status of hemophilic persons. Infection has been found to precipitate bleeding particularly into the skin and joints. Operative emergencies are safely carried out after preliminary transfusion.

2. FAMILIAL THROMBOCYTOPENIC PURPURA

J. C., a boy aged fourteen years, suffered severe nose bleeds since infancy. His mother's maternal uncle and grandfather and two sisters were similarly affected. No other form of bleeding occurred but the epistaxis recurred regularly during the winter months. During upper respiratory infection nose bleeds became more persistent not infrequently associated with petechiae in conjunctiva and palate. There were no evidences of telangiectasis in the upper respiratory tract. The nail fold capillaries were tortuous. The spleen was never felt. The blood picture normal; platelets fluctuating around 110,000; bleeding time 12 minutes; clotting time 4 minutes; clot retraction delayed; tourniquet test varied. The boy was maintained on a high fat and protein dietary with some benefit. Early treatment of infectious invasion minimized several attacks of epistaxis. Winter irradiation by ultra violet light reinforced by 10D cod-liver oil and calcium salts contributed towards the elimination of these attacks. And a donor for intramuscular and intravenous therapy was available but not used.

Essential thrombocytopenic purpura may be a constitutional disturbance characterizing certain families. Cases have been reported in infants of both sexes born of mothers with this disease. In fact, some of the infants have shown multiple malformations in other tissues of the body and some showed striking deficiencies in megakaryocyte formation. Intravenous transfusion is effective if repeated, but intramuscular blood is of little avail. Splenectomy is a surgical risk in newborns. Of those that survive, recurrent bleeding persists more or less throughout life. There is always an hereditary history, its transmission being a dominant characteristic. And the pattern of bleeding simulates that of the affected members of the family. The basis of the bleeding is thrombocytopenic and unless medical supervision minimizes bleeding, splenectomy is indicated.

3. HEREDITARY THROMBOASTHENIC PURPURA

B. W., a ten-year-old girl, had spontaneous hemorrhages since infancy. Her mother had recurrent epistaxis and mild purpura throughout life but none of the other children were affected. The child would suddenly develop severe nose bleeds or ecchymosis over the head, neck and extremities without any apparent exciting cause. At seven years a loosened tooth was followed by bleeding of the gums for two weeks. At eight a vaginal hemorrhage stimulated menstruation. She was variously treated for purpura and hemophilia. The Hgb. 55 per cent; R.B.C. 3.1, W.B.C. 7800, polys. 71 per cent; monocytes 15 per cent; lymphs. 12

per cent; platelets 395,000; clotting time 6 minutes; clot retraction delayed. Bleeding time from right ear lobe 10 minutes; left ear lobe 32 minutes; tourniquet test positive. Bleeding was arrested locally by means of tampons saturated with fresh blood obtained from the father. Only repeated intravenous transfusions were effective in aborting the duration of spontaneous hemorrhages.

Children may be born with hemorrhagic purpura without thrombocytopenia. It is transmitted by the mother to both sexes. Recurrent bleeding may be spontaneous or traumatic. The blood picture is normal excepting for the changes incident to the simple loss of blood. But the platelets are always normal in quantity but defective in quality. They show abnormalities in size, shape and staining qualities with consequent failure of agglutination. Therefore, the bleeding time is prolonged, clot retraction retarded or absent and the tourniquet test positive. Therapy is based upon procedures for supplying normal platelets only possible by intravenous transfusions. All other platelet therapy is ineffective and splenectomy useless.

I have witnessed exitus following splenectomy in a ten-year-old girl with this condition. She had recurrent epistaxis and purpura since birth like her mother. Her blood picture was characteristic of thrombocytopenic purpura but neglected hemorrhage became uncontrollable when splenectomy was performed. I followed the course of this disease in two brothers whose mother experienced milder purpuric bleeding. One boy had hemorrhagic measles. Both boys responded well to protection from trauma, prevention from infectious foci, early arrest of purpuric symptoms and repeated transfusions before bleeding became uncontrollable.

4. HEREDITARY HEMORRHAGIC TELANGIECTASIS

J. G., a thirteen-year-old twin girl, developed repeated nosebleeds. The other twin was normal but the grandmother, paternal uncle and nephew had similar attacks. The Hgb. 60 per cent; R.B.C. 4,000,000; W.B.C. 8500; polys. 65 per cent; platelets 280,000; clotting time 3 minutes; bleeding time 5 minutes; clot retraction 3 hours; tourniquet test negative. Examination of the nasal and mucous membranes showed multiple anginoma as the local cause for bleeding.

Puberty first precipitates bleeding varicosities which characterize this developmental defect. It is transmitted by both sexes and affects both. Inherited defects in the venous channels are usual in the nasal and buccal mucous membrane but hemoptysis, gastric hemorrhage, uterine bleeding, hematuria and even rectal bleeding may result from such telangiectasis. The blood picture is normal and so there is no excessive bleeding or bruising from other sites of the body excepting from the dilated vessels. The treatment is local and as yet not specific.

5. TRANSITIONAL HEREDITARY HEMORRHAGIC DISEASES

H. C., a fourteen-year-old boy, revealed an unusual hemorrhagic picture. The family was free from hemorrhagic heredity. Recurrent nosebleeds from infancy alternated with purpuric eruptions, joint lesions and hematuria. On examination the boy showed petechiae of the mucous membranes, ecchymosis over the extremities and acute hemarthrosis. The Hgb. 70 per cent; R.B.C. 4,000,000; W.B.C. 5900; polys. 70 per cent; lymphs. 20 per cent; platelets 450,000; clotting time 18 minutes; bleeding time 40 minutes; clotting retraction positive; tourniquet test positive.

Such is the blood picture of an atypical hemorrhagic problem. It conforms to both hemophilia and to thrombocytopenic purpura. It demonstrates the futility of following pattern pictures for diagnostic nomenclature. Hemorrhagic patients respond to proper measures corrective of their disturbance rather than to those applicable to the disease label. In no other disease mechanism is individualization of diagnosis and treatment essential. Amongst the chronic hemorrhagic disturbances exist entities intermediate between the so-called primary hemorrhagic diseases. Hemophilia is etiologically an endogenous disease of certain mesenchymal structures as are the purpuras thrombocytopenic and thromboasthenic. Hence combinations of such defectiveness exist simultaneously in these tissues giving rise to chronic transitional disturbances. Our observation of such cases has contributed more to our clinical conception of hereditary heterogeneity than to our creation of corrective measures in their behalf.

SUB-TOTAL VERSUS TOTAL HYSTERECTOMY

By MAX DANZIS, M.D., Newark, N. J.

Read before a General Session of the Medical Society of New Jersey at the Annual Meeting, June 6, 1934

For many years the question as to whether a total or subtotal hysterectomy should be performed, when the removal of the uterus for fibroid growths is indicated, has been discussed quite frequently. Many writers of prominence, whose writings by virtue of their position as surgeons and teachers are accepted as authoritative, have entered into this discussion, but to this day there is still no unanimity of opinion among surgeons on this much disputed subject.

On the one side we have those who advocate total hysterectomy in all cases subjected to operation for uterine growth, basing their contention mainly on the fact that in a certain percentage of cases—admittedly small—cancer of the cervix has and will develop many years after a subtotal hysterectomy; that the additional operative risk involved in doing a total hysterectomy, both from the standpoint of mortality and morbidity, is not much greater than in the subtotal, and one is therefore not justified in leaving behind the cervix, which is a potential source for future cancerous involvement.

On the other side, we have almost an equally large group who advocate subtotal hysterectomy as a comparatively safer procedure, in most instances, particularly in the hands of the less expert operators. In support and justification of their claim they call attention to the fact that if total hysterectomy were adopted as the only standard operative procedure in all cases, the increased morbidity and mortality that may follow its performance would by far exceed the incidence of cervical carcinoma following subtotal hysterectomy.

This division of opinion is not confined to the American surgeons. It is equally prevalent among the European surgeons. In a series of articles on this subject, published by five prominent French surgeons between 1929-1933, one finds that the writers are almost equally divided in their opinion. The partisans of total hysterectomy advocate it as the only preven-

tive measure against cervical cancer, and claim that the additional operative risk should be ignored. Those who object to it do so on account of its length of execution, accidents to ureters and bladder, greater liability to infection, etc. Attention is called to the fact that even total hysterectomy does not prevent cancer formation in the vaginal scar. In a series of 36 cases of vaginal scar carcinoma reported by Hartmann and his co-workers, there were two cases in whom total hysterectomy was done previously for non-cancerous lesions, in whom carcinoma in the vaginal scar developed subsequently.

A similar difference of opinion prevails in a group of articles which have appeared in the American surgical literature, between 1929-1934. Some advocate the total abandonment of subtotal hysterectomy. They believe that thorough cauterization of the cervical canal does not eliminate the danger of cervical cancer, and that the higher mortality of total hysterectomy is based on old statistics. Men of equal experience believe that total hysterectomy will never be popular as the subtotal; that later cancer of the cervix should not be considered an indication for complete hysterectomy; that if cervical lacerations or erosions are present, they should be cauterized or repaired before the abdominal hysterectomy is done. It is interesting to note that in a report of 1700 cases of endocervicitis, treated by cauterization, over a period of 15 years, in the Boston Free Hospital for Women, not one single case of carcinoma of the cervix is known to have developed, which would indicate that cauterization may be a prophylactic against subsequent cervical carcinoma.

Many writers have attempted to estimate the frequency of cervical carcinoma after subtotal hysterectomy, but the ratio between the total number of cervical carcinoma and the total number of subtotal hysterectomies has not been definitely estimated. Its incidence has been accepted by various authors to be about

one per cent or even less. In a series of 9308 cases of subtotal hysterectomies, with a subsequent follow-up, reported by Tarnier, Albrecht, Sanders and Teasaure, between 1924-1928, 45 or one-half of one per cent developed cervical carcinoma. In a group of 4785 subtotal hysterectomies reported by Graves, Hochman, Gagey, Roque and Tarnier, 44 or about one per cent developed cervical carcinoma several years after the operation. Only one case, or 0.6 per cent, out of 178 cases reported in my series, developed carcinoma of the cervix.

The difference in mortality rate between the two types of operations has also been variously estimated by individual writers.

In a large series of cases, approximately 10,000, gathered from nine different sources from the recent surgical literature, in which are included reports from several prominent American clinics, the mortality in subtotal hysterectomy varies from .79 per cent to 4.2 per cent, the average being 2.2 per cent. In a fairly large series of total abdominal hysterectomies gathered from six different surgical sources the mortality rate varies from 1.8 per cent to 7.9 per cent, the average being 3.5 per cent. In a group of 169 subtotal hysterectomies performed by 26 different surgeons between 1932 and 1934 in one of our local hospitals, there were two deaths, a mortality of a little over one per cent; whereas the mortality of total hysterectomy performed by 13 different surgeons from the same group is close to ten per cent. The low mortality in the total hysterectomies occurred in the more highly specialized surgical clinics, but even in the hands of the very skillful surgeons the mortality rate may be high. Ellis E. Möller of Sweden reports a mortality of 6.9 per cent in 117 cases of total hysterectomy and Doederlein's mortality is 5 per cent.

The morbidity rates following total abdominal hysterectomy are uniformly higher than in the subtotal hysterectomy. Accidental injuries to the ureters, rectum and bladder are not sufficiently rare to be entirely ignored. Spencer reports two accidental injuries in 325 cases of panhysterectomies. There were two bladder injuries resulting in vesico-vaginal fistulas, where the panhysterectomy was done for

a non-cancerous condition in 24 panhysterectomies performed in one of our local hospitals. A fact worthwhile stressing, indicating the seriousness of this type of operation in the hands of the less expert.

In other words, comparing the mortality and morbidity between the two types of operation, one is strongly impressed with the fact that the mortality rate gathered from a large series of cases performed by many surgeons is much higher in the total than in the subtotal, and the same is true of the morbidity rate.

In order to establish definitely the incidence of carcinoma in the cervical stump, the mortality and morbidity rate in both types of operation, in my own patients, I have attempted to study the end-results of 317 hysterectomies, of all types, performed by me during the last 15 years. Included in this group are 258 cases of subtotal, 18 total abdominal and 41 total vaginal hysterectomies. There were three deaths in the entire group, a mortality of 0.9 per cent. All deaths occurred in the subtotal hysterectomies, previous to 1926. There is no death in the 214 consecutive hysterectomies performed since that time. This, I believe, is due to better preoperative preparation, a more perfected operating technic and a more careful selection of the types of anesthesia.

We were able to trace only 220 cases of that number, six of whom have died several years after the operation from causes other than cancer of the cervix. The remaining 214 returned for examination for the purpose of this study. In the 178 cases of subtotal hysterectomies that we were able to trace, there was only one case of carcinoma of the cervix, which developed two years after the operation, an incidence of 0.6 per cent. All six that died several years after the operation are included in the subtotal group, and among the causes of death we find that one died of carcinoma of the breast with lung metastasis seven years after operation and one died from cancer of the stomach nine years later.

While we were able to discover only one case of cervical malignancy, we did find a certain percentage of postoperative morbidity, some of which could have been obviated by a total uterine extirpation, but upon further

analysis we find that these conditions yielded readily to other forms of treatment. There were four cases of cervical prolapse, three of which were associated with relaxed and lacerated pelvic floors. Three of these cervixes were subsequently removed and the pelvic floor repaired. None of them showed any microscopical evidence of malignancy. Four patients were found to suffer from small cervical polypi protruding from the external os. The patient's attention was called to their existence when they returned for their follow-up. They were removed and the bases cauterized. Subsequent examination showed cervixes well-healed. Ten of the follow-up cases suffered from cervical erosions, which yielded readily to cautery treatment. I am not certain whether some of these erosions were not present at the time of operation. If they did exist at that time, cauterization would have established a definite cure. It has been my practice during the last seven or eight years to make a very careful inspection of the vagina and cervix at the time of operation. If there is a mild erosion, the cervix is cauterized and a subtotal hysterectomy is done. Should the erosion be extensive or associated with marked cervical laceration or cystic degeneration, a total extirpation of the uterus is done.

The indications for total abdominal hysterectomy in the 18 cases included in this group were quite definite. Marked endocervicitis and extensive cervical lacerations were present in twelve. Three suffered from early carcinoma of the fundus without any cervical or adnexal involvement. Papillary cystadenocarcinoma of the ovary, with metastases to the Fallopian tubes and opposite ovary was present in two and in one the indication was a very low-location of fibroid. There was no operative death in this group. Three of the five in whom total extirpation was done for carcinoma of the fundus or adnexa died within one year from metastatic carcinoma, despite intensive postoperative radiation.

The indications for total vaginal hysterectomy in this group of 41 cases were second-degree prolapse, with or without cervical laceration and the presence of cystocele or rectocele. Two of the uteri showed upon micro-

scopical examination distinct evidence of carcinoma, although the condition was not suspected at the time of operation. For some reason one of these patients failed to return for postoperative radiation, and, strange to say, she shows no evidence of any spread of the disease one year after the operation. The other patient has received postoperative radiation and is still alive two years after operation, showing evidence of further involvement.

I realize that if the end-results obtained in the group of cases here reported were submitted to a group of surgeons from which they were to draw their own conclusions as to the type of operation to adopt, there probably would be a sharp division of opinion.

My own views on this subject are very definite. If it were conclusively shown that the mortality from total hysterectomy is the same as that of subtotal, or that the operation carries a mortality rate lower than the incidence of cancer in the cervical stump, then the total uterine extirpation would be the rational procedure to adopt. But as it is a well-known fact that operations for fibroid uterus are frequently performed by the casual operator, the substitution of complete for subtotal hysterectomy, as a standard procedure, would cause a tremendous increase in mortality and a still greater increase in morbidity. The increase in the operative mortality would by far exceed the deaths from carcinoma originating in the cervical stump.

Careful examination of the condition of the cervix should be made before supra-vaginal hysterectomy is to be performed, and if it is found lacerated, infected or markedly eroded, the complete operation should be done. On the other hand, if the cervix is normal or only mild erosions are present, which may yield to cautery treatment, then subtotal hysterectomy should be the operation of choice.

CHART 1

Total number of cases	317
Subtotal	258
Total abdominal	18
Total vaginal	41
Deaths	3 or 0.9%

Since March, 1926, there were 214 consecutive hysterectomies of all types without any mortality.

CHART 2

Follow-up based on 305 cases
(exclusive of the 1934 cases)

Total number of patients returned for
follow-up 220 or 70%

Subtotal 178 or 69%
Total abdominal 14 or 77%
Total vaginal 28 or 68%

CHART 3

Number of subtotal hysterectomies followed up .. 178

Living 10-15 yrs. after operation 30
Living 5-10 yrs. after operation 34
Living 3-5 yrs. after operation 93
Living 2 yrs. after operation 15

Deaths several years after operation due to causes
other than cancer of the cervix 6

Cardio-vascular and respiratory disease.. 1
Carcinoma of breast with pulmonary me-
tastases 7 yrs. after hysterectomy..... 1
Carcinoma of stomach 9 yrs. later..... 1

CHART 4

MORBIDITY FOLLOWING SUBTOTAL HYSTERECTOMIES

1. Cervical prolapse 4
2. Postoperative hernias 5
3. Polyps 4
4. Cervical erosions 10
 - a. 6-8 yrs. after operation 2
 - b. 5 yrs. after operation 2
 - c. 3 yrs. after operation 1
 - d. 2 yrs. after operation 4
 - e. 1 yr. after operation 1

5. Other complications 2

- a. Uretero-vaginal fistula; healed spon-
taneously 1
- b. Carcinoma of cervix two years after
operation 1

CHART 5

Total abdominal hysterectomies 18

Operative indications:

- a. Endocervicitis and cervical laceration.. 12
- b. Carcinoma of fundus 3
- c. Papillary cystadenocarcinoma of ovary
with metastases to uterus 2
- d. Low location of fibroid 1

Operative mortality 0

Three of the five cases in whom total
extirpation of the uterus was done for car-
cinoma of the fundus or adnexa, died within
one year from metastatic carcinoma, despite
intensive postoperative radiation.

CHART 6

Total number of vaginal hysterectomies 41

Followed up 28

Living and well 5-10 yrs. 4
Living and well 3-4 yrs. 6
Living and well 1-2 yrs. 17
Living: Carcinoma of thyroid and blad-
der 2½ yrs. after operation 1

Postoperative morbidity:

1. Vesico-vaginal fistula; satisfactorily re-
paired six months later.
2. Pathological report shows "adenocar-
cinoma of body of uterus." Well one
year later. No recurrence.
3. Carcinoma of body of uterus; subsequent
radiation. Patient alive two years later.
4. Granuloma of vaginal scar.

DISCUSSION

Dr. Edgar A. Ill (Newark): To try and save a few lives by extensive and radical surgery and thus increase the mortality rate from an operation which normally has a low mortality rate is not justified. A good surgeon is one who knows where and when to stop. In two gynecological services where I am associated with Dr. Harden, Dr. Herndon, Dr. Glass and Dr. Hill at St. Michael's and St. Barnabas' Hospitals in Newark, we have had only one die since 1928 resulting from a super-vaginal hysterectomy. It would not be fair to increase this mortality by a total hysterectomy to anywhere from 5 per cent to 10 per cent in order to keep only an occasional woman from developing cancer of the cervix. In fact, some cases have been reported where cancer developed in the vaginal scar.

My father, Dr. Edward J. Ill, in 1918 reported 800 fibroid tumor operations and only one had cancer of the cervix, seven years later. At the Howard A. Kelly Hospital, 1804 cases of cancer of the uterus, Dr. Branscomb in the American Journal of Gynecology,

July 1930, reported 46 cases of cancer of the cervix and cancer of the cervical stump. Remember, at the Howard Kelly Hospital, cases of cancer of the cervix drift from all parts of the country. It was 46 cases and not 1804 hysterectomies by Dr. Branscomb. Figures and statistics will give almost any result, in fact, sometimes they tell the truth.

I have treated almost 700 cases of cancer of the uterus since 1919 with radiation and had only one case which previously had a super-vaginal hysterectomy. The increase in morbidity from total hysterectomy is very great. It is almost impossible to get figures from actions of this kind. During my first year of practice, with indigo-carmin and cystoscope, I found three patients where super-vaginal hysterectomy was done with ligation of one ureter and not known by the patient or the doctor. When you take out the entire uterus you are working nearer the ureters at both sides and there is very great danger of ligation and injuries of the ureters.

One ureter can be completely ligated, kidney function will cease and the patient never know it until impairment of the other kidney. Other accidents of the bladder and vesico-vaginal and vesico-rectal and fistula are not rare; lack of support of the pelvic floor, painful scars and gynecological invalids are frequently the result of total hysterectomies and these are not put in the mortality list but are often just as bad.

A careful search of figures will show that incidents of cancer of the uterus with super-vaginal hysterectomy and without is about the same.

Dr. William J. Carrington (Atlantic City): In March of this year there was admitted to the Atlantic City Hospital a woman with advanced carcinoma of the cervical stump. I had performed a supracervical hysterectomy for fibroids three years previously, and the cervix appeared healthy at the time. To the cancer-minded such surgery is open to criticism. Had I done a panhysterectomy in the first place, this woman would, in all probability, be alive and well today.

How frequently does cancer develop in the stump of the cervix following supravaginal hysterectomy?

	Per Cent
Hochman's estimate	0.2
Atlantic City Hospital	0.35
Prestini's	0.5
Tesavro's	0.54
Porgue's	1
Polak's	2
Spencer's	3

Mayo reports 99 such cases which occurred during the past twenty-five years. Of these 55 per cent were first recognized three or more years after the original operation.

A cancer of the stump should be considered a preëxisting lesion if it appears promptly after operation, and a new lesion if it appears long afterward. The exact dividing line is uncertain. Some fix it at eighteen months; others at twenty-four months. We can all agree that if cancer appears three or more years later it is carcinoma de novo. We are, therefore, forced to admit that over half the cancers occurring in after-lying cervixes are preventable if we always remove fibroids by panhysterectomy.

Shall we, therefore, do routine prophylactic panhysterectomies for fibroids instead of the usual supracervical amputations? Let us count the cost. What price must our patient pay? According to Spencer, there is practically no difference in the death rate between complete and subtotal hysterectomy when the operations are performed by competent surgeons. And yet at the Mayo Clinic 3085 supravaginal hysterectomies were attended by a mortality of 1.8 per cent, a difference of 0.6 per

cent, which is higher than half those reporting the incidence (not the mortality) of cancer in the after-lying stump. The price is too high.

But this is not all. You know and I know that non-fatal postoperative complications are far and away more frequent after panhysterectomy than after supracervical form. Injuries to the ureters, bladder, bowel, nerves and veins, shock, ileus and a host of other complications increase the morbidity enormously. In the Atlantic City Hospital we are convinced that the mortality and the morbidity of panhysterectomy is too high a price to pay. During the past five years, from June 1, 1929, to June 1, 1934, ten operators have done 280 hysterectomies:

Gynecological Chief No.	I	37
" " "	II	67
" " "	III	77
" Assoc. No.	I	49
" " "	II	6
Surgical Chief	" I	18
" " "	" II	12
" " "	" III	9
" " "	" IV	2
" Assoc.	" I	3

The operations were as follows:

Supravaginal hysterectomy for fibroids	236
Cauterization of cervix	4
Sturmdorf	6
Electro-coagulation	2
Supravaginal hysterectomy for fibrosis	11
Supravaginal hysterectomy for carcinoma of fundus	4
Supravaginal hysterectomy for inflammatory disease	3
Panhysterectomy for degenerating fibroids	2
Panhysterectomy for fibrosis	2
Panhysterectomy for prolapsus	6
Panhysterectomy for carcinoma of fundus	7
Vaginal hysterectomy for carcinoma	2
Vaginal hysterectomy for prolapsus	6

In the Atlantic City Hospital we believe that more patients will die as a result of complete operation than will die from cancer arising in the stump. We believe that careful pre-operative examination, including biopsy in suspicious cases, should rule out preëxisting and co-existing carcinoma of the cervix. We believe precancerous cervixes should be cored out by the Sturmdorf technique, cauterized or electro-coagulated. We further believe that following supracervical hysterectomy patients should be examined at regular three-month intervals so that the knife or radium can be applied early to those rare cases that later develop carcinoma. We believe in these conservative methods rather than in cutting high, wide and handsome.

UVEAL INFECTIONS

By R. W. BAESEMAN, M.D., M.Sc. (Med.), Asbury Park, N. J.

Read before the Section on Eye, Ear, Nose and Throat of the Medical Society of New Jersey at its 168th Annual Meeting in Atlantic City, June 7, 1934

Volumes have been written on this subject and many more will follow, especially until someone answers why one individual with massive infection will have no symptoms and another will have a severe uveal reaction from one small focus.

Rosenow's theory of specific tissue affinity has been doubted by many. DeLong⁽¹⁾ in a lengthy experiment in which he sectioned over 100 eyes taken from rabbits that had been inoculated with bacteria from patients suffering with uveal infection, was unable to demonstrate this tissue affinity. He followed Rosenow in detail. Many of these eyes showed no involvement.

It is not the scope of this paper to go into the merits of either view. Isn't it possible then that this whole subject falls under an allergic group and in that way accounts for the fact that one patient is immune and another not? Whatever the causative agent may be, what are we to do in ascertaining the origin with our present day knowledge? After having the patient examined and finding no focus, we list it as falling under idiopathic. Are we not guilty of some neglect and something to hide behind?

In reviewing one hundred and twenty-six cases of uveal infection the incidence of causative factors, as nearly as was possible to determine, were as follows:

1. Dental Infections	36	28.57%
2. Infected Tonsils	33	26.20%
3. Idiopathic	16	12.70%
4. Following injury	13	10.31%
5. Multiple (Teeth & Tonsils)	7	5.55%
6. Sinus Infection	6	4.76%
7. Syphilis	6	4.76%
8. Gastro-intestinal	5	3.97%
9. Genito-urinary	2	1.50%
10. Tuberculosis	1	.79%
11. Gall-Bladder	1	.79%

All of these patients had routine dental x-rays, Wassermann, urine, ear, nose, throat and general medical examinations. Males with a history of gonorrheal infection had

a prostatic examination and those falling under the idiopathic group had gall-bladder visualization tests and subjected to high colonic irrigations as well as the Manteaux test for tuberculosis. All cases were studied with the slit-lamp and a number were very early. A definite diagnosis was possible only with this aid. Here we find dust like deposits on the posterior surface of the cornea at a line below the lower edge of the pupil and in the aqueous. These appear from 2 to 5 days before it would be possible to establish a definite diagnosis by any other method. These opacities must not be confused with deposits of cellular elements found in nearly 50 per cent of children's eyes. Both occur in the same location but the latter are much larger in size. In this early diagnosis, we save the patient many painful hours and do not treat them for a simple conjunctivitis, which I am certain we all have been guilty of.

The writer would like to report several case records which were originally listed as idiopathic and later a definite diagnosis was established, much to my embarrassment and I hope to your aid.

Case I. Mr. X., a clerk, aged thirty, was first seen on March 22, 1932. He complained of eyes paining, blurring of vision and lacrimation. Patient gave a history of having acid splashed in his eyes. Five weeks previous, he was seen by another man and had glasses prescribed. Examination—vision O.D. 6/6 -4, O.S. 6/6 -3, with his correction. Pupils reacted to light and accommodation, were equal and regular, palpebral conjunctivitis O₂, and some injection of bulbar conjunctiva O₂. The cornea did not stain and was negative under slit-lamp. There were some few cells in the anterior chamber. Pupils were dilated with homatropine for thorough examination. Ophthalmoscopic examination showed fine dust-like opacities in the vitreous. Nose and throat examination revealed badly infected tonsils. Wassermann was negative, urine

negative. Report from dentist was negative. X-rays were taken. Prostatic examination negative. Blood count and chemistry negative. Routine treatment was given and tonsils were removed. Condition became worse, more floaters appeared in the vitreous. Patient developed many K. P. and vision dropped down to 6/22 O₂. He was seen in consultation by several men and diagnosis confirmed. Patient had foreign protein and about every form of treatment including a series of old tuberculin injections but eye condition remained about the same for a period of six months. One day he presented himself and complained of pain over two incisors. He was immediately sent to the X-Ray Laboratory and definite apical abscesses were present over both teeth. These were extracted and reaction resulted in both eyes. At the end of six weeks his condition was greatly improved and in ten weeks his vision was O.D. 6/9 -4, O.S. 6/6 -2.

There was a definite retinal degeneration in both eyes, more marked in O.D. One year later his condition remained unchanged except for absorption of much of the dust in the vitreous. The vitreous was definitely fluid.

Case II. Dr. R., a physician, aged 27, first seen on August 5, 1930, at which time eyes were refracted with normal vision. There was no pathology present. Next seen July 1, 1933 with a definite iritis of O.D. A complete examination was made at this time and the only focus found was an apical abscess, tooth was extracted and he made an early recovery. On October 20, 1933, patient presented himself with another attack of iritis in same eye. At this time, another dental check-up was advised and it was with a great deal of difficulty his dentist and himself were convinced that another x-ray and check-up were thought in order. The x-ray showed another definite apical abscess and one devitalized tooth, both were extracted, a rather severe reaction followed but he made a speedy recovery.

In both of these cases I feel certain that a very careful dental check-up would have found these foci at the first examination.

At one of the recent National Board Ex-

aminations the candidates were given a complete dental x-ray for examination and asked to find what was wrong. Only a very few were good enough roentgenologists to give the correct answer—"Poor pictures."

We should examine all dental pictures and insist that every case of uveal infection have an electric test for pulp vitality. It is not enough to depend on x-ray alone and we must urge our dentists to include the pulp testing. In so many dental offices this apparatus is not used, and often found out of order.

Haden⁽²⁾ in an examination of 7000 dental films from 500 patients found that 91 per cent of the patients had pulpless teeth that carried infection and did not show in the x-ray. This more than justifies our insistence of pulp testing.

Other often neglected foci are the root fragments found in toothless mouths. Again Haden⁽³⁾ in an examination of 200 jaws or 3200 tooth areas, found 86 or 5.5 per cent that had some portion of the root remaining. Eusterman⁽⁴⁾ of the Mayo Clinic found the same condition in his series of 290 jaws, there being 129 fragments present.

There is some variation of percentages given by different observers for dental lesions. Butler⁽⁵⁾ 12 per cent. B. T. Lang⁽⁶⁾ 40 per cent. William Lang 60 per cent. My own series 29 per cent. It certainly is by far the largest offender today and the one that should be investigated first.

In the male another focus that is so very often over looked is the prostate. It is not enough to ask the patient if he has had gonorrhea and if the answer is negative to dismiss it.

Pelouze⁽⁷⁾ gives these rather astounding figures: 35 per cent of all males over 35 have infected prostate glands that are non-gonorrheal in origin; 61 per cent of these have infected teeth and 69 per cent have infected tonsils. The three go together and the prostate will not clear until the other offenders have been removed. In a series of 100 unselected cases, he found 15 suffering from uveal infections. He cautions the urologist in examinations not to be drastic in treatment, as eye lesions are subject to very severe reac-

tions after massage. Impress this on your urologist.

The question often presents itself as to the best course to follow where we find a number of foci present. There are no set rules to follow but I do firmly believe that only one should be removed at a time. If there are 3 or more teeth infected, it is the better judgment not to remove more than one at a time and depend on the reaction present in determining how fast the remaining should be removed. We have all seen eyes damaged by too drastic removal of teeth. Another thing that is so often overlooked is the failure of the dentist to follow up his patient after the removal of infected teeth. Pelouze states that 64 per cent of his cases show definite infection inside of six months. A very good plan is to do this six months after the first extraction and routinely every year. More often is advisable.

The incidence of syphilis in uveal infections is given in most text books as from 30-60 per cent. Klauder in a personal communication gives this as 3 to 8 per cent. This bears out my own observations.

In the cases of injury, those following operative procedure were included. There is no doubt that we all are too anxious to do surgery before a proper check is made for all possible foci. More and more effort should be made to remove these before intra-ocular surgery is attempted. After all has been done, we still find certain cases of cataract extraction that end all too unhappily. There is no doubt that some of these are sensitive to the lens protein itself and can be desensitized. Much is yet to be desired in that direction.

All cases of tonsil infection cleared up after tonsillectomy but none can say if that infection was the sole cause of trouble as we all know that many cases clear up with only local

eye treatment. In none of these cases were the eye symptoms aggravated by tonsillectomy.

In the cases listed under sinus disease, a definite exudate was found in the offending sinus and eye symptoms improved on drainage of pus. In this connection we must not forget the dictates of Skillern and Ridpath. We may have a very virulent infection present without any pus and because the rhinologist is unable to find pus and x-ray study is negative, infection cannot definitely be ruled out. This often happens in the sphenoid sinus and it is often well that we insist that they be opened up. We have all seen cases of this nature and must not allow a negative report to lead us astray.

The causes of glaucoma still remain a mystery and the end result we know only too well. In making slit-lamp examinations of these cases, I have so often been impressed with the picture of a low grade infection. There is definite pigment migration, more or less atrophy of the iris and frequently cells in the anterior chamber. It is not possible that the filtration angle may be occluded by the exudate from a low grade uveal disturbance and this be the cause of glaucoma. Be that as it may, a search for foci in these patients is to be desired. I have been unable to find any figures on the incidence of focal infections in cases of glaucoma and my series of cases is not large enough to warrant any conclusions.

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DISCUSSION

Dr. Willard G. Mengel (Camden): Cases of uveal infection should be diagnosed early with the aid of the slit-lamp. Vitreous opacities soon appear and it is often difficult to get rid of them, especially when present over an extended period of time.

It is difficult, oftentimes, to determine the etiological factors involved in uveal infections. They occur occasionally in apparently healthy individuals in whom all studies for foci of infection have been negative. These are the cases which are most difficult. The importance of careful dental study

by x-ray and pulp testing must be stressed. It is customary in my practice to look to the teeth first as the offending agent in uveal infections, and it is interesting to know that statistics show dental infections to be more frequent etiologic factors than others.

Great care and judgment must be exercised in the removal of foci of infection. Doing too much in this respect is often more harmful than doing nothing. It is best to open and drain a focus of infection with as little trauma as possible and wait to observe the severity of the reaction affecting the eye. Later, more thorough eradication of the focus may be attempted. Sometimes the reaction following the removal of foci of infection increases the vitreous haze, and this may be permanent, so that instead of improving vision, you may actually cause damage by too radical procedure.

Foci of infection, however, must be removed, but carefully, as the continued effect of the infection on the eye over a long period of time may destroy, finally, the vision and possibly the eye.

In this series of cases, dental and tonsil infections comprised 50 per cent of the total as causative factors, and tuberculosis less than one per cent. Without doubt, infections of the tonsils and teeth are etiologic factors in half of the cases of uveal infection, but it seems to me that latent tuberculosis, as an etiologic factor, is more frequent than indicated in this series of cases. My feeling is that

latent tuberculosis is a factor in many cases in which, after thorough and careful study, no infected focus has been detected. It is difficult to obtain positive tests for tuberculosis in many of these cases, but the use of tuberculin, carefully and in graduated doses, seems helpful in many instances.

Dr. A. Russell Sherman (Newark): I would like to point out, in regard to the usefulness of tuberculin in the treatment of uveitis, that two of the world's foremost ophthalmologists, the elder Fuchs and Professor Meller, after together observing the same patients for seventeen years, the one as chief of clinic and the other as his first assistant, were in complete disagreement as to the efficacy of tuberculin. The one considered it invaluable, the other valueless.

Dr. R. Castorvicjo: In regard to the treatment of tuberculosis uveitis, the ophthalmologists at the last International Congress did not seem to agree. Some of them claimed to have obtained good results with tuberculin treatment; others claimed that tuberculin treatment in cases of true tuberculosis uveitis always had a focal reaction which finally brought blindness to the eye. They considered the cases in which improvement had been obtained with tuberculin as non-tuberculous in which the tuberculin treatment had acted in the same way as foreign protein therapy would have done.

GENERALIZED ARGYRIA

By LOUIS J. B. LeBEL, M.D., Nutley, N. J.

From the Dermatological Service, St. Mary's Hospital, Passaic, N. J. Read before the Staff Conference.

SUMMARY

The blue discoloration of the skin from the internal use of silver salts is now seldom seen; but its possibility is to be considered in view of the extensive use of silver salts in the

treatment of nasal conditions and syphilis. A case is described that resulted from the prolonged use of argyrol in the nose for sinus infection.

The source of any silver found in the human body is either therapeutic, or occupational. The internal therapeutic use of silver has been largely discarded. Formerly silver nitrate was used extensively in the treatment of various gastric disorders and epilepsy. Its use is now confined to its local escharotic action on small lesions, such as fissures, exuberant granulation, tissue, etc., and, in weak solution, as an astringent irrigating fluid in the bladder, rectum, etc. It is also used in the prophylaxis of ophthalmia neonatorum.

The newer organic silver salts are used extensively in the treatment of naso-pharyngeal

and genito-urinary conditions and in the prophylaxis and treatment of gonorrhoeal ophthalmia. The intravenous use of silver-arsphenamine is one of the more recent additions to the list of antiluetic remedies. The chief occupational sources of silver in the body are the inhalation or ingestion of dust in silver workshops, the use of silver nitrate solution in the preparation of silver glass beads, chiefly in Bohemia, and the handling of silver-containing solutions in commercial photography.

Argyria is the term applied to the permanent discoloration of the skin which sometimes follows the prolonged administration of silver

salts. Most authorities recognize two types—a localized type in which the deposition is directly from without; and a generalized type in which the deposition of silver combinations take place universally and indirectly from the blood. I shall consider, here, only the generalized type.

The first clinical evidence of generalized argyria is a bluish line along the gum margins, similar in location to that of lead poisoning. The appearance of such a line should immediately contraindicate further silver therapy. The mucous membrane of the mouth, the conjunctivae, the skin of the face, and finally the skin of the entire body gradually assume a bluish discoloration, depending upon the amount of silver absorbed. The color is more intense (slate-colored) on the exposed surfaces of the body than on the portions covered by clothing. It is quite probable, from the literature, that argyria causes no other signs or symptoms than the skin manifestations.

Generalized argyria may follow the absorption of either inorganic or organic silver compounds. According to A. O. Gettler et al.,⁽¹⁾ the portal of entry in generalized argyria is usually the gastro-intestinal canal. Some silver may enter the blood stream through absorption by the mucous membranes, but it is doubtful if enough is ever absorbed this way to cause the clinical picture of generalized argyria. In those cases reported, due to the long continued use of organic silver preparations in the nose and throat, it is probable that much of the silver was swallowed, and that it was absorbed by the gastro-intestinal tract, which resulted in the generalized argyria.

Crispin,⁽²⁾ Tobler,⁽³⁾ Goldstein⁽⁴⁾ and Davis⁽⁵⁾ have reported cases of generalized argyria following the use of organic silver preparations.

Only two instances have been reported in which generalized argyria developed as a result of absorption of silver through the body surface, both of these being extensive burns treated with weak silver nitrate solutions.

The minimal amount of silver necessary to produce generalized argyria probably varies considerably. In the case of silver nitrate it is probably about 25 to 30 grams of this salt

taken over a period of six months. It is impossible to estimate the amount of silver salt ingested or absorbed following naso-pharyngeal or other local applications.

Spiegel⁽⁶⁾ has recently recorded three cases of a discoloration of the skin resembling argyria, following the use of silver-arsphenamine and bismuth, and he sets the maximum dosage for safety at 8 grams. Becker and Ritchie⁽⁷⁾ have reported two cases of argyria following overtreatment by silver-arsphenamine, in which the clinical diagnosis was substantiated by histologic examination and histochemical studies. Each of their cases received over 15 grams, above which argyria is apt to be produced, according to these authors and Habermann.⁽⁸⁾ Cannon⁽⁹⁾ has recently reported four cases of argyria in a series of 104 cases treated with silver-arsphenamine. These cases occurred after an average of 75 injections and 12.57 gm. of the drug over an average period of five years.

PATHOLOGY

Microscopic examination of a piece of skin in generalized argyria shows the presence of opaque granules beneath the epidermis in the upper layers of the corium. These granules are found deposited along and between the bundles of a collagen and elastic fibres, but never within the cells.

Gettler et al.⁽¹⁾ report a complete autopsy and chemical analysis performed upon the most severe case of generalized argyria ever reported in the literature. The subject was known as the "Blue Man" of the circus, and chemical analysis showed an estimated total silver content of the body of 90 to 100 grams. Histological studies of tissues in this case showed that the silver-containing granules were present not only along and between the bundles of collagen and elastic fibres, but also within the phagocytic cells of the spleen and lymph nodes. This is the only instance in which silver was observed within the cytoplasm of cells. They also observed that the specific cells of the various organs did not contain silver, but that the latter was deposited in the supporting connective tissue, and that the deposited silver granules did not cause the more

or less characteristic foreign body "cellular reaction" on the part of the body.

Gettler outlines the method for the isolation and identification of silver in the tissues, which is briefly as follows:

The tissue is ground, acidified with nitric acid, dried, and ashed.

The ash is leached successively with hot water, ammonia, and 50 per cent hot nitric acid.

The three filtrates are combined, and hydrochloric acid (HCl.) added. Silver is precipitated as silver chloride (AgCl.).

This precipitate is soluble in ammonia, potassium cyanide, and sodium thiosulphate, and changes to a bluish color in exposure to light. Some of it, dissolved in ammonia, when treated with sulphuretted hydrogen results in a black precipitate which is insoluble in ammonia or HCl.

Some of this black precipitate, when dissolved in hot nitric acid, evaporated to dryness, taken up with water and tested separately with the reagents gave results as follows:

- Potassium iodide, yellow precipitate.
- Potassium chromate, blood-red precipitate.
- Sodium phosphate, yellow precipitate.
- Potassium ferrocyanide, white precipitate.
- Potassium ferricyanide, brownish red precipitate.

Another method for the identification of silver in the tissue is the use of the spectrograph. It is interesting to note in the report on Spiegel's cases,⁽⁶⁾ that spectrographically, silver was found in the normal skin of five new-born infants. There seems to be no explanation for this at the present time, unless it is that enough silver was absorbed from the mucous membrane of the conjunctiva as a result of prophylaxis against ophthalmia neonatorum to cause a silver band in the spectrogram. This was not mentioned in Spiegel's paper.

A review of the literature shows that most authorities agree that we do not possess any therapeutic agent which influences the clinical picture of generalized argyria. However, Cannon, in his report, says that two of his cases

showed a marked decrease in the intensity of the pigmentation after a year's treatment with sodium and calcium thiosulphate given intravenously and by mouth.

CASE REPORT

Patient, S. E., female, white, age 62. Occupation, school teacher. Seen by the writer in consultation with Dr. Martin Meehan.

The patient was admitted to St. Mary's Hospital, Passaic, New Jersey, March 1st, 1932, with the complaint of a cough, expectoration of thick greenish sputum, discharging ears, and shortness of breath, of three weeks' duration. She had had similar attacks frequently for the past five or six years.

The family history was unimportant.

She stated that seven or eight years ago she had a chronic cold in her head and sinus trouble, and a physician ordered her to put 3 drops of 15 per cent argyrol solution in each nostril 3 times a day. She did not report back to the physician and had been using the argyrol thrice daily ever since. She stated that 5 or 6 years ago she noticed that her skin was becoming dark in color, but she did not associate this with the use of argyrol. The writer saw this patient in consultation with Dr. Meehan about one year before admission to the hospital, and made a tentative diagnosis of argyria, based upon the history and inspection.

Upon physical examination the most striking feature was the marked discoloration of the skin, which varied from a bluish gray to a slate color. The discoloration was most marked on the face, neck, hands, wrists, and forearms. The remaining areas of body skin showed a faint, but very definite tinge of discoloration. The conjunctivae were markedly discolored, as were the external auditory canals and the pinnae of the ears. No definite lines of pigmentation along the gum margins were to be seen, but the buccal mucosa appeared darker than normal.

Other physical findings were the characteristic signs of emphysema, chronic bronchitis, and a double chronic purulent otitis media.

The writer ordered a biopsy from behind the ear, and the pathological examination of this tissue by Dr. Franz Kastler was reported as follows:

The specimen is a piece of skin about half the size of a penny, showing an ashen-grey discoloration.

The microscopic examination shows no pathological changes of the epithellum and corium except the deposition of minute opaque granules right underneath the epithellum in the upper layers of the corium, occupying rather the intracellular spaces than the cells themselves.

Diagnosis—Exogenous pigmentation, argyria.

The pulmonary and ear conditions were treated by Drs. Martin Meehan and Ernest Reeves and improved considerably, but the pigmentation of the skin was unchanged when the patient was discharged on May 12th, 1932.

Chemical and spectrographic tests for the identification of silver in the tissues were not performed.

STATE SOCIETY ACTIVITIES

REPORT OF THE EXECUTIVE SECRETARY

At the request of President Ely, the Executive Secretary prepared the following report on his activities for the five months, June to October, inclusive. This report was submitted to the Trustees at their meeting on October 28, 1934, and its publication in The Journal was ordered.

Following the Annual Meeting, the summer months' "let down" of County Society activities provided time for planning to improve the work of the approved projects as a result of the experience gained.

CO-OPERATION WITH E. R. A. MEDICAL RELIEF PROJECT

Field visits, in coöperation with the new State E. R. A. executive in charge of hospital and medical services (Mr. J. D. Coleman), were made to several counties where joint meetings between County E. R. A. directors and the Medical Advisory Committee members of the County Medical Society were being held. Many misunderstandings and conflicts were eliminated and the services coördinated. The greatest present difficulty centers on the financial difficulties—charges and delays in payment. Misunderstanding within the E. R. A. (staff workers) seems to be a large factor in this difficulty, but increasing experience tends to improve the service, and the coöperation and understanding of both groups. The attitude toward each other is vastly improved over six months ago, and the progress made in New Jersey is distinctly noteworthy in spite of the difficulties encountered, which were many and varied.

A new appreciation of the difficulties involved in medical service and in administration has come about on both sides, and this has had a salutary effect in lowering the enthusiasm of the administrators for "State Medicine", and also in initiating a certain number of the medical profession into the necessary "red tape" involved in organized effort.

It is evident that the outcomes of the E. R. A. Medical Relief project will have been distinctly "educational" to all concerned, as well as beneficial to the patients.

THE "PUBLIC HEALTH HOUR" PROJECT

The "Public Health Hour" project needs to be speeded up. At this time only one-fourth of the members of the Medical Society have applied for the smallpox vaccine and the diphtheria toxoid. If the response of individual physicians is not representative of the majority at least, clinics *must* and will be continued, and extended by Health Departments for the

inclusion of the children in the lower age-levels. The Public Health Departments *by law* are charged with the responsibility of protecting the health of the public (community), and of keeping financial and other *records* of their activities, supplies, and accomplishments. Unless the physicians will give service and records equal to or better than those furnished by clinics, the aim of the "Public Health Hour" will fail. We need more and better co-operation. Our activities must be organized, scheduled, and dispatched regularly. If the present "Public Health Hour" plan can be improved, or a better plan substituted, so much the better—but we cannot afford to *fail*.

CO-OPERATION AND INTERPRETATION

Interpretation to, and coöperation with other community organizations and agencies interested in their health problems is increasingly the aim of the New Jersey Medical Society. Here the physician acts most effectively when he is formally delegated by his Medical Society, and is recognized as an official representative of organized medicine, as is the case in the E. R. A. and Public Health Hour projects.

These aims have been promoted through talks, editorials, correspondence, and personal contact with "key" persons in medical, educational, and social fields.

These efforts will be continued and expanded in order to impress upon the other community groups the necessity of keeping within the scope of their proper functions, and of calling upon the organized medical profession for aid and advice in the solution of the health problems involved in their work.

EXECUTIVE OFFICES' SERVICE

It is difficult to visualize clearly the services in the central offices. They are many and varied, but may be roughly classified as "administrative", "informative", and "coöperative"; and the "scheduling", "accounting", and "scouting" phases of our work.

"Scouting" activities include those by which The Medical Society President and Officers are kept informed of activities within other organizations and agencies that might affect the interests of physicians.

"Scheduling" means the preparation for and

conduct of meetings and conferences held and of addresses given by members or executives of The Medical Society.

The other classifications are self-evident as to their functions.

The development of the *County Medical Society* as a *Service Agency* for medical participation in organized efforts is desirable in view of the threat of "State Medicine" which, if it comes, will stress "organization for service". Should we not anticipate this demand

while the control is still ours? If State Medicine does not materialize, we shall even then be in better condition to provide both offense and defense against other attacks, and at the same time to secure a better coördination of our medical services.

Respectfully submitted,

Approved LEROY A. WILKES,
LANCELOT ELY. *Executive Secretary.*
President.

OBITUARIES

J. HOLBERT CONOLY, M.D.

Dr. J. Holbert Conoly, of Gloucester, Camden County, died on November 21, 1934, of pneumonia. He was a native of Maxton, N. C., and graduated from the University of North Carolina. He received his doctor's degree from Temple University in 1925, and since then has practiced in Gloucester.

He was a member of the Camden County Medical Society, as also is his brother, Dr. L. N. Conoly, of Camden.

WILLIAM M. GOODWIN, M.D.

Dr. William Munson Goodwin, aged 64, of 75 Congress Street, Newark, died on November 21, 1934, from a heart attack at his home. He had been in poor health since 1927.

Dr. Goodwin was born in Waterbury, Connecticut, and was educated at Wesleyan Academy and Yale, and graduated from the College of Physicians and Surgeons of Columbia University in 1894.

His entire medical career was spent in Newark. For thirty-nine years he was surgeon for the Pennsylvania Railroad. He was a member of the Essex County Medical Society and of several fraternal orders.

EDWARD P. UPTEGROVE, M.D.

Dr. Edward P. Uptegrove, of Vernon, died at the Linn Hospital, Sussex, on November 22, 1934, aged 59 years. He graduated from University of Penn-

sylvania Medical School in 1899, and began practice in Hamburg in 1900. He remained there until May, 1913, when he moved his office to Vernon.

JOHN VICTOR LYNN, M.D.

Dr. John Victor Lynn died on Tuesday, November 13, 1934, of heart disease, aged 58, in the Holy Name Hospital, Teaneck.

Dr. Lynn was born in Leesburg, Virginia, August 7, 1876. He graduated from the Hahneman Medical College of Chicago in 1905 and served his internship at Metropolitan Hospital, New York City, in 1906. He practiced in Kansas City, Missouri, until the World War, when he served in the Naval Transport Service. After the war he practiced in Ridgefield, New Jersey.

He was director of Physio-therapy at the Holy Name Hospital at the time of his death.

EDGAR CARROLL, M.D.

Dr. Edgar Carroll died in his home in Dayton, Middlesex County, on November 18, 1934, aged 81 years. He was one of four brothers who were physicians, one being physician to President Lincoln during the Civil War. He was descended from a long line of doctors and was born in Keene, Ohio. He graduated from Jefferson Medical College in 1880, and had practiced in Dayton for over 40 years. He was the Middlesex County physician for over 25 years.

LIST OF PHYSICIANS DYING IN NEW JERSEY DURING OCTOBER, 1934

Supplied by the Department of Health

NAME	PLACE OF DEATH	RESIDENCE OF DECEASED	DATE OF DEATH
Henry Obuchowski	Connecticut	Newark	August 8
William A. Clark	Trenton	Trenton	October 2
Frieland B. Gilpin	Elizabeth	West Cranford	October 2
Sophie B. Scheel	Clifton	Clifton	October 10
Flora Adams	Hackensack	Hackensack	October 10
Margaretta Valentine	Teaneck	New York City	October 9
Cyrus Knecht	Maplewood	Maplewood	October 30
Clarence Schellenger	Deptford	Deptford	October 16
Richard Garrison	Dover Twp.	Toms River	October 14

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

DECEMBER, 1934

4	Camden	13	Essex
6	Hudson	13	Passaic
11	Bergen	13	Somerset
12	Mercer	14	Atlantic
12	Salem	19	Middlesex
12	Ocean	20	Gloucester
12	Union	20	Morris
13	Burlington	26	Monmouth

JANUARY, 1935

1	Camden	10	Essex
3	Hudson	10	Passaic
8	Bergen	11	Atlantic
8	Cumberland	15	Warren
8	Sussex	16	Middlesex
9	Mercer	17	Gloucester
9	Ocean	22	Hunterdon
10	Burlington	23	Monmouth

ATLANTIC COUNTY

R. A. Kilduffe, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held Friday, November 9th, 1934, at the Ambassador Hotel, Atlantic City, with 78 members and guests present and the President, Dr. D. B. Allman, in the chair.

The minutes of the October meeting were read and approved.

Applications for membership were received from Dr. S. G. Stewart, Johns Hopkins; Dr. Harry S. Hoffman, Hahnemann; and Lewis Feinstein, New York University. These were referred to the Board of Censors for action.

Dr. Darnall, reporting for the Library Committee, said that Dr. Crile's new book was in the Library.

Dr. C. M. Fish stated that the Committee on the Care of Physicians' Widows and Children would report fully at the next meeting.

Dr. Allman appointed the following Nominating Committee for the officers of the Society for 1935: Chairman, C. H. deT. Shivers; S. Barbash, J. Poland, S. L. Salasin, and E. H. Harvey. They are to report at the next meeting.

PHYSICIANS' LIEN LAW

Dr. Allman announced that the Physicians' Lien Law is now in effect, and stated that a large number of the men had gone to the hearing on October 15th. He said that there were only two people there who were opposed to the law, an insurance adjuster and an attorney; and that when they saw how well represented the medical profession was, they did not take any action.

The schedule of fees has been filed, and all physicians in the county are now working under it. One error in the printed schedule sent out to the members was the fee for minor nose and throat operations, which should read \$25.00 instead of \$250.00.

If any member of the Atlantic County Society has not received his schedule, it will be mailed by the Secretary upon request.

Dr. Johnson requested information as to obtaining the blanks for filing these liens; and Dr. Conaway stated that the State Society was having them printed, and would mail them to the Secretary of each County Society from whom they can be obtained upon request.

Dr. Conaway stated that the Atlantic County was the only County so far who had its schedules filed with the County Clerk and approved by the Court.

The Secretary read a letter from the group of members of the Atlantic City Medical Society composed of the doctors on the North side of the City, in which they stated that they hoped to cooperate with the Atlantic County Medical Society in every way. He also read a letter from Dr. Allman thanking the Atlantic City Medical Society for its offer.

THE E. R. A.

Dr. J. S. Irvin, reporting for the Medical Advisory Committee, stated that, in order to distribute the work more evenly, the E. R. A. had made a ruling that no doctor could receive more than \$250. per month.

The administration has also decided to allow treatment by chiropractors, osteopaths, etc., when their services are recommended by physicians. Their fees are to be one-half to two-thirds of their regular fees.

Dr. Irvin stated that there had been some contention over the fact that, when the E. R. A. started paying in cash instead of food orders, there were numbers of people who immediately became too sick to work. It is necessary to appoint a group of examiners to check up on these individuals. He personally did not select the men but the committee asked certain ones to act as examiners and sent the names to Mr. Cross. Shortly after that Dr. Coward called Dr. Irvin and told him that he wanted at least two colored physicians in that group. As the colored doctors are getting a very large proportion of the work here, because of the large colored population, he felt that there was no reason for their being on this list of examiners.

A letter from Mr. Cross received some time later stated that they had appointed three colored doctors, two in Atlantic City and one in Pleasantville, in addition to the names submitted by our committee.

In taking up the matter at a meeting of committee chairmen from the various counties, Dr. Snedecor agreed with Dr. Irvin and stated that the State Committee would back our committee up in any action taken in this matter.

Dr. Fish said that in picking the men for this examiners' group he had purposely picked those who were not doing a great deal of the E. R. A. work.

With reference to the matter of the selection of examiners for the E. R. A., Dr. Wilkes, Executive Secretary, said that this matter had been discussed at a meeting of the State Advisory Committee and Mr. Coleman representing the State E. R. A. It was agreed that the proper procedure would have been to appeal to the State E. R. A., and the State Advisory Committee, and let them settle the matter. That all medical appointments shall be made by the County Medical Society Advisory Committee, is a sound principle to be insisted upon.

Dr. Quinn said he thought all physicians on this Board of E. R. A. Examiners should be approved by the Society. He said we should have the courage to write to the Director of the E. R. A. and state this fact.

It was moved and seconded that the Secretary write to the Executive County Director informing him that the addition of names to the list of Examiners which we submitted was not in accord with the agreement entered into by the E. R. A. and the State Medical Society; and that this Society, therefore, protests the action of the Atlantic County Advisory Board. The motion was carried.

The Secretary said he felt that we should have a member elected by this Society on the County Advisory Board.

A motion was passed that the Society request the State Advisory Council to appoint a member of this Society of our selection as a member of the Advisory Board of Atlantic County.

THE PUBLIC HEALTH HOUR PROJECT

Dr. LeRoy A. Wilkes, Executive Secretary, said that the Public Health Committee is anxious to hear that the work of the Public Health Hour is being carried on, and that the immunizing materials are being supplied. He asked if there were any questions about the work that he could answer.

Dr. Salasin, Health Officer of Atlantic City and a member of the Public Health Committee of the Society, said that he had not been called upon to supply very much of the State's immunizing material to other physicians, but that he had been doing a tremendous amount of the work at City Hall free. He said that he felt the profession had not fully availed themselves of the opportunity of doing this work, and that the Public Health Hour program as far as Atlantic County was concerned should be carried out more actively.

Dr. Wilkes said that in the prevention of disease it is up to either the medical profession or the Board of Health of a community to see that this work is done.

He said that the death rate for diphtheria had fallen; but that although the death rate from all acute communicable diseases has declined, when it is taken on a percentage basis, we find that the death rate for diphtheria, for which we know we have a preventive measure, has not declined in proportion in these last five years. Before this it was practically the same as it is now.

Dr. Irvin stated that he had signed up to do this work, but that no one had ever come to him to have it done. He felt there had not been enough popular publicity in regard to it.

Dr. Allman said he felt Dr. Salasin should have

told the people who came to his clinic to go to the offices of the different physicians who had expressed their willingness to do the work.

He also said the Public Health Hour should be advertised more extensively, and that there should be some way to reach the people to tell them what the program means. One thing emphasized was that each doctor should sell the idea to his own patients.

Dr. Rosenblatt said he felt that the people who knew they could have the work done at City Hall free were certainly not going to the doctors' offices and pay for it.

Dr. Quinn said that he felt there was more of the work of immunization and vaccination being done than we realized. He said he was sure most of the work was being done by the family physician. Some 200 or 300 indigent children who had to be vaccinated this year were sent to City Hall.

He said it would be very easy to inaugurate a campaign of some sort in the schools and the meetings of the Parent-Teachers Associations, as Mr. Chenoweth could be relied upon to carry out any plan we might suggest.

Dr. Quinn said he did not feel that extensive newspaper advertising should be attempted because we have gone far enough in pauperizing the public as it is.

Dr. Wilkes said that in Mercer County letters had been sent to all principals and supervising principals asking them to tell of the Public Health Hour, and to advise parents to take their children to the family doctor before the second year.

The Meale Johnson Company is sending out birth certificates with a complete schedule stating when the different health procedures should be carried out by the family doctor as the child grows.

Dr. Salasin said he had just found some funds which he could spend for advertising, and he is sending out a letter to the parents of every child born in Atlantic City in the last year urging them to bring their children to the family physician for immunization and vaccination.

SCIENTIFIC PROGRAM

The Scientific Program was presented by Dr. George Crile, Director, Cleveland Clinic Foundation; Surgeon, Cleveland Clinic Hospital, under the title of "The Adrenal Sympathetic System and Its Diseases". To be printed in a later number.

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held jointly with the Bergen County Pharmaceutical Association November 13th at the Hackensack Hospital, with Dr. A. Liva, President, in the chair. Approximately 250 physicians and pharmacists were present.

There was no business except election to membership of the following:

Regular:

Dr. J. L. York, New Milford.

Dr. J. P. Baldwin, Bergenfield.

Junior to Regular:

Dr. J. F. Benjamin, Ridgewood.
Dr. V. A. Lamberto, Lyndhurst.

Junior:

Dr. N. F. Myers, Glen Rock.
Dr. A. R. Frederick, Rutherford.
Dr. John Calabrese, Rochelle Park.

The following applications for membership were read:

Regular:

Dr. G. T. Erickson, Hackensack.
Dr. Lewis R. Thompson, Wyckoff.

Junior:

Dr. D. C. Clarie, Closter.
Dr. Louis C. Cartnick, Woodridge.

Mr. Gorman, President of the Bergen County Pharmaceutical Association, spoke for that organization. He said that much good should come out of such a joint meeting of physicians and pharmacists.

Dr. Levitas, in charge of the Scientific Program, introduced the four speakers of the evening, three of whom represented the Pharmaceutical Association.

Dr. Charles W. Ballard, Ph.D., Professor of Materia Medica, Columbia University, College of Pharmacy, emphasized the close relation between the physician, the pharmacist and the patient, and decried the way proprietary remedies have been advertised, suggestive of sponsorship of the medical profession. He also thought that the detailed salesmen were successful in introducing many proprietary remedies to the medical profession much to the detriment of the patient, physician, and the pharmacist.

Dr. Robert P. Fischelis, Ph.D., President of the American Pharmaceutical Association, and Secretary and Chief Chemist, New Jersey State Board of Pharmacy, gave a résumé of the financial status of the average drug store in this country. He stated that the average gross annual business totaled \$28,000, 40 per cent of which was in prescriptions, and 60 per cent in other goods. He said that the average net profit on prescriptions was \$1000 per year. The 50,000 to 60,000 drug stores in the United States had an average of eight prescriptions per day at an average of 80 cents each. Dr. Fischelis felt that the control of drugs should be in the hands of those who know most about them, and that not just anyone should be allowed to set up a factory for proprietary remedies.

Dr. Adolph F. Macquier, Ph.D., Professor of Pharmacy, Rutgers University, urged the doctors to use U.S.P. and National Formulary remedies which were just as good as proprietary articles in most cases and cheaper.

(See page 674 for editorial comments on the meeting.)

Dr. Walter S. McClellan, M.D., Medical Director, Saratoga Springs Commission, spoke on "Hydrotherapy and the Indication for the Use of the Natural Carbonated Mineral Waters", describing the various methods of applying the waters and the indications for their use.

Refreshments were served after adjournment.

BURLINGTON COUNTY

H. P. Shipps, M.D., Reporter

The 105th Annual Meeting of the *Burlington County Medical Society* was held at the St. Mary's Guild House in Burlington on Wednesday afternoon, November 14th, 1934.

The following officers and committees were elected for the coming year:

President, J. Howard Hornberger, of Roebling.
Vice-President, J. Lester Small, of Medford.

Secretary and Treasurer, George T. Tracy, of Beverly.

Reporter, H. P. Shipps, of Delanco.

Censors: R. D. Anderson, of Burlington; E. R. Hunter, of Delanco; J. S. Conroy, of Burlington.

Four Delegates to the State Society: Edgar J. Haines, Warren Rodman, George Tracy, Richard Anderson.

Four Alternates to the State Society: Emlen Darlington, Robert Imhoff, Emma P. Metzger, Howard Curtis.

Member of the Nominating Committee of the State Society, George T. Tracy.

Alternate to the Nominating Committee of the State Society, Warren Rodman.

Delegates to Camden County Society: Harry Bauer and Dean Le Favor.

Delegates to Gloucester County Society: Fred Lucas and Carlton Hogan.

Delegates to Ocean County Society: Luther Hartman and Louis Viteri.

Delegates to Atlantic County Society: A. B. Peacock and D. B. Ulmer.

Delegates to Salem County Society: Edgar Haines and Howard Hornberger.

Delegates to Cape May County Society: G. E. McDonnell and R. E. Haldeman.

Chairman of Section on Practice of Medicine, Harry Rogers.

Chairman of Section on Surgery, Joseph Kuder.

Chairman of Section on Gynecology and Obstetrics, Howard Curtis.

Chairman of Section on Specialties, Louis Viteri.

Committee on Credentials: Joseph Stokes and Marcus Newcomb.

Committee on Post-Graduate Courses: D. B. Ulmer and Howard Curtis.

The Society voted to change its meetings to the second Thursday evening of each month. This is a digression from the long established custom of having only five stated meetings each year.

The retiring President, Dr. Jacob M. Davis, in his address gave an interesting résumé of the work and accomplishments of the Society during the past year.

The Secretary announced that a hearing on the Physicians' Lien Law will be held on December 13, and that a number of members should attend it.

After the business session a fine turkey dinner was enjoyed by those present. The dinner was served by the ladies of the St. Mary's Guild.

ESSEX COUNTY

Associated Physicians of Montclair and Vicinity

Bertram S. Perham, M.D., Secretary

A meeting of the *Associated Physicians of Montclair and Vicinity* was held at the Ella C. Mills' Home on Friday evening, October 26th, 1934.

Dr. Ralph I. Alford, of Montclair, was unanimously elected to membership of the Society.

Dr. Warren Ripley discussed the subject of immunization and vaccination of children by the doctors in their offices.

Dr. Frank H. Lahey, of Boston, was then introduced and read a paper on various types of hyperthyroidism and myxedema, and the rôle surgery plays in their treatment.

Dr. Ralph E. Herenden, of New York City, read a paper on roentgentherapy of hyperthyroidism, giving interesting statistics of patients as compared to those treated by surgery.

Drs. Victor B. Seidler and Jennings S. Lincoln, of Montclair, discussed Dr. Lahey's paper, and Dr. Robert D. Schimmelpfennig, of Montclair, discussed Dr. Herenden's paper.

Dr. Lahey then answered several questions brought up by this discussion.

Refreshments followed.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The 116th regular monthly meeting of the *Gloucester County Medical Society* was held in the Hotel Pitman, Pitman, on October 15, 1934, with 17 members present, as follows:

Drs. Wilson Stout, E. R. Ristine, R. K. Hollinshed, H. B. Diverty, B. A. Livengood, I. W. Knight, William Pedrick, H. W. Wright, Duncan Campbell, H. M. Fooder, Louis Ruttenberg, Don Weems, M. F. Lummis, Fuller G. Sherman, W. J. Burkett, Dorothy Rogers, and A. B. Black.

Visiting delegates were: Dr. A. G. Kinney, Dr. Patterson, and Dr. Oram Klein, Camden County; and Dr. Muriel Ramsey, Cumberland County.

An address by Dr. L. K. Ferguson, Chief of the Surgical Out-Patient Department of the University of Pennsylvania Hospital, was a feature of the meeting. He gave an illustrated talk on "Varicose Veins" that proved very instructive.

Officers elected were:

President, E. R. Ristine.

Vice-President, Henry L. Sinxon.

Secretary-Treasurer, Ralph K. Hollinshed.

Reporter, H. B. Diverty.

Censors: H. Wilson Stout, C. I. Ulmer, I. W. Knight.

Delegates elected to the State Society for three years: C. I. Ulmer; Don Weems, Alternate.

Two years: R. K. Hollinshed; B. A. Livengood, Alternate.

One year: William Pedrick; E. R. Ristine, Alternate.

Nominating Committee for the State Society: E. B. Downs; R. K. Hollinshed, Alternate.

Trustees: Duncan Campbell, three years; J. H. Underwood, two years; William Brewer, one year.

Delegates to County Societies:

Salem—Samuel Ashcraft, I. W. Knight, B. A. Livengood.

Cape May—H. B. Diverty, Duncan Campbell, William Brewer.

Camden—H. B. Diverty, E. R. Ristine, Fuller Sherman, W. E. Crain.

Cumberland—W. J. Burkett, M. F. Lummis, I. W. Knight.

Burlington—H. W. Wright, Oram Wood, Don Weems.

Atlantic—C. A. Bowersox, Victor Barrows, H. M. Fooder, Ralph L. Moore.

Mercer—H. L. Sinxon, C. C. Sheets.

Dr. Ristine appointed the following committees:

E. R. A. Committee:

H. L. Sinxon	Horace M. Fooder
Fuller G. Sherman	William Pedrick

Public Health Committee:

I. W. Knight	Charles Pedrick
H. W. Wright	

Program:

C. A. Bowersox	Fuller G. Sherman
Don Weems	

Public Relations:

E. E. Downs	B. A. Livengood
W. J. Burkett	

Committee for Post-Graduate Courses:

H. B. Diverty	C. I. Ulmer
Don Weems	

Maternal Welfare:

J. H. Underwood	Dorothy Rogers
W. E. Crain	

Following the meeting a buffet supper was served, with the members of the Ladies' Auxiliary as guests.

HUDSON COUNTY

John M. Connell, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held at the Carteret Club, Wednesday, November 7, 1934. The meeting was called to order by the Vice-President, Dr. T. J. Schuck, at 9:30 p. m. The President, Dr. E. J. Chapman, was unable to attend because of illness.

REPORT OF EXECUTIVE COMMITTEE

The Secretary read a communication received from Dr. Lancelot Ely, President of the Medical Society of New Jersey, with particular reference to the activities and functions of various County Committees for the coming year.

The Secretary Dr. Thomas Brennock gave a brief report of the Annual Conference of the County Secretaries and Reporters, held at the Stacy-Trent Hotel in Trenton. Dr. Brennock and Dr. J. N. Connell represented Hudson County at this Conference. A report of this meeting will be given at the De-

cember meeting of the Hudson County Medical Society.

RADIO TALKS

The Secretary read the following communication received from H. F. Downes, Radio Forum Conductor:

"This is to request that you extend to the members of your society an open invitation to appear as 'guest speaker' at one of our Public Health Forums which are conducted twice weekly over the local radio stations WAAT, and WHOM.

"We have since last June presented these programs weekly and have had the welcome privilege of introducing as our 'guest speaker' more than twenty members of your society as well as one member of the Hudson County Dental Society, and we have every reason to believe, based upon the number of requests we have received for copies of 'talks', that the idea behind the program is catching on and that we can anticipate even more results as the program continues.

"There is no advertising of any kind permitted during the program, and copies of 'talks' that may be requested are made from the originals by clerks of this department and mailed promptly. There is no censorship on the choice of topics, with the single exception that politics or any matter not directly concerned with the advance of *adult health consciousness* is not desired. The program is definitely nonpartisan, and is intended as an educational medium, through which members of the medical profession, in sacrificing some time because of their unselfish interest in improved health, may offer sound and competent advice to our listeners and so counteract many abuses such as self-medication in an intelligent manner.

"We have been advised by your Chairman of Publicity that efforts are being made to present a program of the type we have been conducting on a daily schedule. It appears to us that such a type program can easily be 'overdone'; and permit us to suggest that full consideration of this angle be accorded when the matter comes under consideration at your meeting.

"We are anxious to coöperate in every way possible with your society in programs of health advancement; and we will, if it is so desired, change the introduction to our program from 'The Hudson County Board of Health and Vital Statistics' to read 'Presented by the Hudson County Board of Health in coöperation with the Hudson County Medical Society', or to any similar title you may think desirable.

"We have devoted much time and detail to these radio presentations, and feel that it is now a fixed period with a growing audience of listeners. Our request that consideration be accorded the possibility of 'overdoing' such radio periods is based upon a desire not to jeopardize the interest which is now being exhibited through overproduction and repetition."

REPORT OF PUBLICITY COMMITTEE

Dr. Thomas A. Higgins, Chairman of the Publicity Committee, informed the members of the Society that the Publicity Committee feels that

there is need of conveying correct medical information to the public to offset the extensive advertising carried on by those who may be called the competitors of the Medical Profession. The plan calls for medical education talks over the radio by members of this Society, calling attention to the fact that the physician whose life work is the treatment of disease and the maintainance of good health is the person best fitted to give medical advice. Talks will be given on cancer, tuberculosis, diabetes, heart disease, periodic health examinations, vaccination, diphtheria immunization, minor injuries, infections of the hand, significance of headache, backache and abdominal pain, appendicitis, gastric and duodenal ulcer, gall-bladder disease, focal infection and its effect on general health, obesity, thyroid disease, respiratory infections including pneumonia, and other practical subjects. The talks are designed to emphasize the importance of signs of disease and that early treatment by a physician is advisable. The talks will conclude with messages such as "see your Doctor if you are not well", and "if you need medicine, you need a doctor", also "ask your physician's advice on every health matter".

Dr. Higgins in his report said that there is no need for saying a word against any other person or organization giving medical service or advice. The Publicity Committee's plan is to educate the public to the fact that the Doctor is the best fitted person to take care of their medical needs, and if the program succeeds, these people will be satisfied with nothing less than expert treatment by a Doctor of Medicine when they are sick.

The authoritative source of all medical information should be the Hudson County Medical Society, the New Jersey State Medical Society, and The American Medical Association. The Publicity Committee's plan on behalf of the Hudson County Medical Society will produce immediate benefits both to the public and the physician. Even with a daily program, each member will only be asked to prepare a 15-minute talk once during the year.

The Publicity Committee fully realizes the importance of censorship of all talks. Only recognized medical facts, and statements designed to elevate public respect and esteem for the physician will be permitted on the broadcast. All broadcasts will be for *the physician*, but against no one. A copy of each talk will be given to the Publicity Committee at least 48 hours before it is to go on the air. This will allow the committee ample time to censor the material and arrange for alterations or omissions where necessary.

Tonight the Publicity Committee of the Hudson County Medical Society requests that the membership of the Society vote in favor of a motion directing the Publicity Committee to proceed immediately with the radio broadcast program as outlined.

Dr. Barbarito moved that the Publicity Committee proceed with the plans that were made for the broadcast, beginning Saturday, Sunday, and Monday, November 10, 11, 12. Motion carried.

SCIENTIFIC SESSION

At the end of the Business Meeting, Dr. Schuck presented the speaker of the evening, Dr. Francis Ashley Faught, Chairman of the Commission on Medical Economics, Philadelphia County Medical Society, whose subject was "Medical Practice Under State Medicine in the United States."

Dr. Schuck also presented Dr. Frederic E. Elliott, chairman of the Committee on Economics of the Medical Society of the State of New York, who discussed Dr. Faught's paper.

Adjournment at 12:12 a. m.

MIDDLESEX COUNTY

G. F. Hilker, M.D., Reporter

The regular monthly meeting of the Middlesex County Medical Society was held at Ffaff's Restaurant, Metuchen, New Jersey, on November 21st, 1934.

The minutes of the previous meeting were read and approved. The following communications were read by the Secretary:

1. A letter from State President Ely appointing Dr. Fithian a member of the Committee on Economic Security, which will consider health insurance and socialized medicine from the standpoint of New Jersey physicians.

2. A report of the Conference of Secretaries and Reporters which supported the proposition that the reporter should be a member of the House of Delegates.

Dr. Weber, reporting on the Doctors' Lien Law, stated that the fee schedule has been filed and will come up for a hearing before Judge Lyons on December 14, 1934.

Dr. Sherman, delegate to the Essex County Welfare Commission, reported on the work of the commission. Its aim is to reduce maternal mortality and morbidity by having county commissions appointed who will superintend maternity work. Dr. Sherman moved that a commission for Middlesex be appointed, consisting of twelve or thirteen men, half of which will serve for two years and the rest for one year. This was seconded and passed.

A resolution was passed ordering a floral tribute for Dr. Edgar Carroll, of Dayton, New Jersey, who passed away on November 18, 1934.

The Treasurer's report was given and the members were urged to promptly pay their 1935 dues.

Dr. Wilentz announced that the new Middlesex County E. R. A. plan will be tried in Perth Amboy and Woodbridge beginning December 1st, 1934.

Dr. Mark appointed a Nominating Committee consisting of Dr. McKernan, Dr. Henry Jr. and Dr. Wantoch.

SCIENTIFIC SESSION

The speaker of the evening, Dr. Pol N. Coryllos, was then introduced and gave a comprehensive lecture on "The Surgical Aspects of Pulmonary Tuberculosis". Dr. Coryllos classified the disease as follows:

I. Acute Form—

1. Exudative benign type—not to be treated surgically.
2. Caseous pneumonic type, which gives best results with surgery.

II. Chronic Form—

1. Proliferative type which is not surgical unless cavities are present.

The mechanism of spontaneous and artificial closure of cavities was explained, after which the technic and indications for thoracoplasty and pneumothorax were given.

Dr. Coryllos stated that in his series of cases of thoracoplasty, the mortality has been reduced from 23 per cent to 7 per cent.

The paper was discussed by Drs. Silk and Fehrer.

MONMOUTH COUNTY

Samuel Edelson, M.D., Reporter

A special meeting of the *Monmouth County Medical Society* was held at the Monmouth Memorial Hospital on August 22, 1934, with the President, Dr. John E. Maher, presiding. The purpose of the meeting was to consider the adoption of a Fee Schedule as required by the Physicians' Lien Law. Dr. Maher turned the meeting over to Dr. William G. Herrman, chairman of the committee which drew up the schedule.

Dr. Herrman outlined the provisions of the Physicians' Lien Law, explained the necessity for a fee schedule, and told of the work which the state and county committees had done to arrive at the figures.

Dr. Alfred Podell spoke against the adoption of any fee schedule, and offered the motion that "while we are in favor of the Physicians' Lien Law, we do not believe a set fee schedule should be adopted at this time". The motion was seconded by Dr. Hunt, not because he was in favor of it, but to merely expedite the vote. The motion was put to a vote and lost. Dr. Podell wished a record made of his protest and predicted that the Society would regret its action.

Dr. Herrman then read the fee schedule which, if adopted, will be on file in the County Clerk's office. It was moved by Dr. Herrman, seconded by Drs. Jamison and Campbell, and carried by vote, that the fee schedule should be adopted.

A motion was made by Dr. Herrman that 250 copies of the schedule, and 1000 copies of the Physicians' Lien Law be printed after the final adoption of the schedule. The motion was seconded by Dr. Holters, and carried.

EXECUTIVE COMMITTEE REPORT

A meeting of the Executive Committee was held at the Monmouth Memorial Hospital on Tuesday evening, September 18th, with the following members present: Drs. Baisdell, Fairbanks, Altschul, Watkins, Gosling, Herrman, Nichols and Featherston.

Dr. Frank Altschul, Chairman of the Program Committee discussed the plans for the coming

months. It was stated that the Dental Society is anxious to meet with us and has offered to furnish a speaker on some economic subject.

The report of the activities of the E. R. A. in Burlington County was read and ordered filed.

A discussion took place relative to the work of the Monmouth County Chapter of the American Red Cross in the recent Morro Castle disaster. While it was acknowledged that all points were covered by the doctors, the work lacked coördination. It was suggested, therefore, that a unit be organized which would be in continuous readiness for action, the functioning of which would be known to all members of the Society.

Dr. Nichols brought up the subject of the treatment of State wards by private physicians. It was stated that the State Board would enter into an agreement with the physician rather than have its charges treated at hospital clinics. Dr. Nichols was instructed to have a contract drawn up for presentation at the next meeting.

Applications were received from Dr. Manlius Lazrow, of Matawan, and Dr. Alexander Jordan, of Manasquan, to participate under the "Agreement between the County Medical Society and the Emergency Relief Administration". The application of Dr. Jordan was approved, but as Dr. Lazrow is a member of the Middlesex County Medical Society, the Secretary was instructed to inquire into his relations to that Society.

A letter was received from Dr. O. R. Holters in regard to the next meeting of the Medical Society on October 24th, when Dr. Alexander O. Gettler, of New York, will speak on "The Rôle of Toxicology in a Medico-Legal Autopsy". Dr. Holters feels that this paper would be of great interest to the members of the legal profession and suggested that we invite to the meeting the members of the Monmouth County Bar Association, as well as the Ocean County Medical Society and the nurses from the training schools in the Fitkin and Monmouth Memorial Hospitals. It was voted that an invitation be extended to these various groups.

A second letter was read from Dr. Holters in which he stated that under the provisions of the E. R. A. no extra charge could be made for an urinalysis. The doctor felt that an additional allowance should be made for these examinations, and that they be made by a pathologist. As it was the opinion of the Executive Committee that this is already a part of the agreement, the Secretary was instructed to make inquiries from the E. R. A.

The Secretary was instructed to arrange for another meeting with the Advisory Board of the County E. R. A. The purpose of this meeting will be to consider certain changes in the Agreement if entered into for the next year.

The Secretary was also ordered to write to the State Medical Society suggesting that one or two doctors be included on each County E. R. A. committee.

A letter was received from the Committee on the Doctors' Lien Law in which it was suggested the addition of two introductory paragraphs to the State fee schedule. As these items and several other minor changes have already been included

in the county schedule, Dr. Herrman was authorized to file the schedule in the County Clerk's office, and to arrange a date for a public hearing.

After a prolonged discussion, it was voted that the Secretary write a letter of protest to the State Board of Trustees against doctors from various metropolitan districts practicing medicine in Monmouth County during the summer months. In some instances, it was found that the doctors were not licensed to practice in the State of New Jersey. In fairness to the local physicians, it is felt that the matter should be taken up with the State Society in an effort to control the situation. (See Journal, November, page 614.)

An announcement was received from the Treasurer of the State Medical Society that the 1935 assessment for Monmouth County would be \$13.00 per capita, the same as last year. The Executive Committee voted that the usual County Fee of \$4.00 be added to the County dues, which would make a total of \$17.00 for the 1935 dues. It is strongly urged that payment be made on or before December 1, 1934, so that all the names will appear on the official State membership list.

OCTOBER MEETING

The October meeting of the *Monmouth County Medical Society* was held in the Auditorium of the Jersey Central Power and Light Co. on October 24, 1934. Alexander O. Gettler, Ph.D., L.L.D., Professor of Chemistry at New York University, Professor of Toxicology at Bellevue Medical College, and Toxicologist to New York City, spoke on the "Rôle of Toxicology in a Medico-Legal Autopsy".

Dr. Gettler cited numerous instances of deaths caused by carbon monoxide, ether, chloroform, tetra-ethyl lead, carbon-tetrachloride, alkaloidal poisons, and drowning. In discussing these deaths, cases which had attracted nation-wide attention were mentioned. Dr. Gettler spoke of methods of detecting various poisons; and of the micro-chemical methods of detecting small amounts of ether in brain tissue. He spoke of the method he had devised for differentiating drowning in salt water from that of drowning in fresh water.

Dr. Gettler made a plea for the adoption of medical examiners' offices which would be similar, in their component parts, to that of New York City. The systems in force in most parts of the country were obsolete, he stated. The two best departments of this kind were those of New York City, and those of Essex County, New Jersey. He stated that medical examiners' offices should be non-political in their make-up; and that these offices should have complete charge of any body in which death had taken place under suspicious circumstances. If some counties were not large enough to have a fully equipped office, two or three counties could unite with a single toxicological department. In New York City, the cost of an autopsy, of complete toxicological examination, and of physicians going to court, if necessary, was \$4.00 per case.

Considerable discussion followed Dr. Gettler's address.

HOSPITAL CONFERENCES

The following program was presented at the clinical conference of the *Fitkin Memorial Hospital* on November 11, 1934:

- I. Pernicious Anemia.
- II. Infectious Mononucleosis.
- III. Renal Calculus.
- IV. Post-abortion Pelvic Abscess.
- V. Case for Diagnosis.
- VI. Carcinoma of Head of Pancreas.

The following program was presented at the Clinical Conference of the *Monmouth Memorial Hospital*, on November 14, 1934:

- I. Obstructive Jaundice.
- II. Caesarian Section.
- III. Perinephritic Abscess.
- IV. Infectious Arthritis.
- V. Pernicious Anemia.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

The first of a series of "Clinical Club" meetings of the *Morris County Medical Society* to be conducted this year was held on the evening of November 22, 1934, at All Souls' Hospital in Morristown. President McMahon called the meeting to order with an attendance of approximately sixty members and guests. The President then turned the meeting over to Dr. D. W. Teller, Morristown, President of the Clinical Club of All Souls' Hospital, who presided and introduced the speakers.

The subject of the evening was "Rheumatic Heart Disease", by Dr. George J. Young, Morristown, who presented the histories of two interesting cases, one a white boy of three years and the other a white boy of eighteen years. The pathological discussion and demonstration was by Dr. Lawrence W. Smith, Pathologist at All Souls' Hospital. The subject and discussion were illustrated by lantern slides and motion pictures, and specimens were described and passed around for inspection.

The presentation was received with marked interest, and Dr. Teller expressed appreciation of the masterful way in which Dr. Young and Dr. Smith covered the subject. Discussion was invited and entered into by Drs. Larson, Beaver, Schmldt, Harris, Musetto, Johnson, and Burrit. Various points raised were answered by the speakers.

As the discase was limited to the Temperate Zone throughout the world, it was advanced that recurrence might be prevented by a change of climate; that as the management is similar to that of the tuberculous, provision might in the future be made for their care similar to that for the tuberculous; and that the commencing time and extent of exer-

cises depends upon the amount of cardiac reserve and the cardiac damage of the individual.

At the conclusion of the scientific chapter, inviting refreshments were enjoyed.

PASSAIC COUNTY

Sigurd W. Johnsen, Reporter

The regular meeting of the *Passaic County Medical Society* was held at the Valley View Sanatorium, Preakness, New Jersey, on Thursday, November 8, 1934, Dr. H. F. Willard, President, presiding.

The minutes of the annual meeting with election of officers were read and accepted.

Dr. Pol Coryllos, attending surgeon, Metropolitan and Seaview Hospitals, New York City, then gave an excellent talk on the newer surgical aspects of pulmonary tuberculosis, illustrated by lantern slides.

From the discussion which followed, the consensus of opinion was that Dr. Coryllos had given a remarkable description of what was being done in an entirely new field. The results of the operative treatment on tubercular patients with cavitations were most gratifying.

Drs. Spickers, DeYoe, Dingman, Hagen, and others led the discussion.

A rising vote of thanks was then extended to Dr. Pol Coryllos for his splendid talk.

The business session was then opened. The following resolution was read, and unanimously accepted:

Whereas, the Legislature of the State of New Jersey, at the session of 1934, passed Chapter 109, Pamphlet Laws of 1934, extending the Hospital Lien Act to include the charges of physicians and surgeons, and by the terms of said act the Medical Society in each County is required to fix and determine their reasonable schedule of charges to be filed in the office of the County Clerk:

Now, therefore, be it resolved, that the schedule of charges hereto annexed be and the same are hereby determined to be a reasonable schedule of charges in accordance with Chapter 109, Pamphlet Laws of 1934, and the Secretary is directed to cause a copy of said schedule to be filed in the office of the County Clerk and also to give due notice of the hearing on said schedule by publishing same for at least four insertions in the Paterson Morning Call, a newspaper circulated in the County.

A motion was made, seconded, and passed that the President appoint a committee to revise and draw up the By-Laws to date.

The meeting was then adjourned, and the members assembled in the dining room of the Valley View Sanatorium where they were served with excellent refreshments.

THE WOMAN'S AUXILIARY

REPORT OF DELEGATES TO TWELFTH ANNUAL MEETING OF THE WOMAN'S AUXILIARY TO AMERICAN MEDICAL ASSOCIATION

Cleveland, Ohio

JUNE 11-16, 1934

By Viola B. Hubbard

I was very happy to represent New Jersey as a delegate at the meeting in Cleveland last June held by the National Auxiliary. We arrived early and I was fortunate to be invited to attend the Pre-Convention Board Meeting on June 11th. I will endeavor to give you a brief résumé of its activities.

The meeting was called to order at nine o'clock at the Hotel Carter. After the usual announcements, reading of minutes and roll call, the Jane Todd Memorial was discussed and announcement made that the Southern women had taken over that work and the Auxiliary committee for that work would be dissolved.

Mrs. Percy, of California, Treasurer, presented a plan to regularly increase the Corrine Keene Freeman Revolving Memorial Fund, and after discussion it was voted to present it at the General Meeting on the following day.

It was voted to base the budget on the dues received the previous year.

Mrs. Doane, of California, Chairman of Legislation, presented a motion to abolish the Committee on Legislation as the work now being done by that committee could be done by the Public Relations Committee of each state.

The matter of changing the official name of the Auxiliary was brought up and discussed. The new name being suggested was "The American Medical Auxiliary".

Mrs. Bartlett, of Missouri, Historian, brought up the question of disposing of the remaining copies of the booklet entitled "The First Twelve Years", which had been published by her committee. It was decided to refer that question and paying for the publication to the general meeting.

This meeting lasted until four o'clock with a recess for luncheon.

GENERAL MEETING, JUNE 12TH

Mrs. Clyde Cumber, Cleveland Social Chairman, extended very cordial greetings.

The Memorial Service conducted by Mrs. Haggard, of Texas, assisted by Mrs. Charles Corn, of South Carolina, who sang, was very impressive.

At the roll call New Jersey was represented by three delegates.

Mrs. Blake was a very sweet and capable presiding officer. I trust you all will have a chance to meet her and know her better in Atlantic City next June.

Mrs. Tomlinson, the President-Elect, was just as sweet and popular as when she visited us. The reports of the Chairmen were inspiring.

The report of Mrs. Blake, the President, may be read in the Journal, so I will not report it here. The reports of the officers will also be published.

Mrs. Philip Doane, of California, Chairman of Legislation, introduced Dr. Junis B. Harris, California, who addressed us on "The Technic of Putting a Bill Through the Legislature". He suggested that a request should be sent that you as a Chairman want a hearing on a bill. Send a petition to the committee having the bill that you want a hearing and go well prepared with facts to educate the Senators on the issues of the bill.

Dr. Harris seemed to think it was more effective to write representing a group rather than as an individual to the Senators.

WEDNESDAY, JUNE 13TH

It was voted to put \$500.00 out of the surplus in the treasury into the Corrine Keene Freeman Fund and to change its name to "The Corrine Keene Freeman Revolving Fund".

Mrs. Fielding Lewis reported that the Southern Medical Auxiliary had taken over the "Jane Todd Memorial".

The reports of the State Presidents were deferred until the afternoon. The report of the Nominating Committee was received and the officers were elected as presented.

The speaker of the session was Dr. Bauer, Director of Bureau of Health and Public Instruction. He told how he sent around a questionnaire to the Auxiliaries asking whether or not the Auxiliary was active, to which 268 answers were received. He mentioned several booklets which could be obtained by sending for them to Chicago.

The National Auxiliary luncheon was held in the Rainbow Room. Officers of the American Medical Association were present. Each had a short message for us.

After the luncheon, Dr. J. A. Meyers, of Minnesota, talked and showed slides about preventive medicine regarding tuberculosis. He advised all college students be tested for it.

At the close of Dr. Meyers' address, the State Presidents gave their reports, very briefly.

THURSDAY, JUNE 14TH

Two conferences were held on Thursday at nine o'clock. I attended the one on Hygeia. Since I did not want to prolong the sessions of the General Meeting and after a conference with some of the officers, I decided to present the letter sent to the State Auxiliary by Essex County about their attitude toward Hygeia at this Conference rather than at a General Meeting.

The letter presented was discussed very seriously and it was decided that the National Chairman be instructed to bring the matter to the attention of the editor and see if the faults could be corrected in the future. Mrs. Herbert, the Chairman, asked to have a list of the objectionable articles.

Suggestions were made as to trying to get an appropriation from the Boards of Education to put the magazines in the schools. The magazine was published at the request of some teachers for authentic health information. It is the organ of the Medical Society and if you repudiate it you repudiate your own doctor. Get back copies and make loan packets from clippings. Ask your Librarian how she values Hygeia.

At the Board meeting held at 10:30 a. m. it was decided that the wives of Navy men have a free membership.

Also state members are members of the A. M. A. The state is to decide the status of its own members.

At the General Meeting at 11 o'clock, committee appointments and plans for the year were presented.

I have not touched upon the social activities, which I assure you were very enjoyable.

Respectfully submitted,

Viola B. Hubbard.

REPORT OF THE WOMAN'S AUXILIARY TO THE A. M. A.

By Mrs. Frederick Adrian Kinch, Westfield, N. J.

The following report is submitted of the Twelfth Annual Meeting of the Woman's Auxiliary of the American Medical Association held in Cleveland, June 11th to 16th, 1934.

On arriving in Cleveland on Monday afternoon, June 11th, the first thing on the program was a dinner and reception at Hotel Carter, headquarters of the Woman's Auxiliary, honoring the Past Presidents, National Board of Delegates and wives of Officers and Delegates of the A. M. A. The toast-mistress was Mrs. Willard Bartlett, of St. Louis. There were about two hundred present. I was glad to see one familiar face at the head table, Mrs. R. W. Tomlinson, Wilmington, now President of the National Association, who had just arrived from Atlantic City, having attended our own State Meeting. Mrs. H. V. Hubbard, of Plainfield, and Mrs. E. R. Mulford, of Burlington, were among the guests. Mrs. Blake, the National President, called on the Presidents of the different States for words of greeting. Mrs. Hubbard responded, representing Mrs. Casselman, the State President of New Jersey; and Mrs. Mulford as an ex-member of the National Board.

On Tuesday the day began with a Southern breakfast honoring Mrs. Southgate Leigh, Mrs. James Blake and Mrs. Robert Tomlinson of the Woman's Auxiliary. This was followed by the General Meeting at 9:30. The morning was occupied by the reading of routine reports. At 12 noon, the members of the Auxiliary went to a luncheon and bridge at the Lake Shore Hotel. A fashion revue from two of the large stores of Cleveland was given during the afternoon.

In the evening we attended the Opening General Session of the American Medical Association in Music Hall of the Auditorium.

The splendid reports at the Wednesday morning meeting from the State Presidents could not but arouse our interest and enthusiasm and encourage

us to greater effort to carry on the work of the Auxiliary.

At one o'clock the Auxiliary Luncheon was given in the Rainbow Room of the Hotel Carter. The guest speaker was Dr. J. A. Meyer, of Minneapolis, on Preventive Medicine, illustrated by lantern slides.

In the evening, there was a Musicale and Informal Reception at the Allen Memorial Medical Library. This building was erected to the memory of the late Dr. Allen, of Cleveland.

On Thursday morning, Conference Meeting on Public Relations and Hygeia was held, Post-Convention Board Meeting, Appointment of Committees and Plan of Work for 1934-35.

After the meeting members left for luncheon at the Country Club, followed by another style show. Everything was exhibited from an elaborate coiffure to pink toe nails; abbreviated bathing suits to long train gowns; after all this we hope we would know how to dress when we arrived home.

On our return to the city we stopped at "Glen Allen", the home of Mr. and Mrs. Francis Fleury Prentiss. We were granted this special favor because Dr. Allen was Mrs. Prentiss' first husband. The Japanese garden and pool are quite unusual. The pagoda with a fountain in the center had a roof of tiles brought from Syria made in the twelfth century. The roof was supported by columns surmounted by gargoyles.

"Bring-Your-Husband Dinner" in the evening at the Hotel Carter for the women guests of the American Medical Association and their husbands, followed by the President's Reception and Ball at the Hotel Cleveland brought the Convention to an end.

The keynote of the meetings seemed to be for the members of the Auxiliary to become "Medically Conscious" so that the medical profession would be advanced a timely opportunity and in every way.

REPORT OF PUBLIC RELATIONS COMMITTEE

By Loretta C. Schultz

I submit the following reports from six counties on their Public Relations:

A program with suggestions and recommendations was sent each chairman on public relations

throughout the state. Reports from the following County Chairmen received:

Bergen County sponsored an Essay Contest for all students in High Schools on "Diphtheria Im-

munization", in view of the campaign being waged by the Medical Society, the judges being prominent members of Bergen County Medical Society. Two prizes were given for the best essays.

Camden County held a meeting in February, with an attendance of over 200. Dr. Stanley Reiman, of Philadelphia, spoke on Cancer Research. Camden County also has a Speakers' Bureau, speakers being supplied by the doctors.

Woodbury reports a reciprocity meeting, the speaker being Miss Thelma Parkinson, whose subject was Taxation.

Essex County reports interesting work in keeping up the broadcasting. Reciprocity meeting, invitations being extended to all various health organ-

izations and Parent-Teacher Associations. Dr. Allen Ireland was the guest speaker.

Passaic County reports much activity with wonderful coöperation from Dr. Frederick Lee, our health officer, and Mrs. Cecelia Brogan, director of the Paterson Bureau. March 9, Dr. Levy was the speaker—subject, Supervision of Health and Examination of the Pre-School Child. Dr. Levy also showed the slides. It was most interesting. Almost 150 members and guests present. Also meeting earlier in the year, when Miss Smyth of the State spoke on Child Hygiene. At this meeting Miss Helen Cusack represented Valley View Tuberculosis Sanatorium for Passaic County, and Dr. McMillen and Dr. Millard, the Medical Society.

REPORT OF COMMITTEE ON PUBLICITY

By Paulina A. North, Chairman and Reporter

Three messages were received from the President, Mrs. Hubbard. Fifty-four reports were sent in by twelve of the fourteen Auxiliaries in the state.

Atlantic County led with nine reports, and Gloucester and Hudson each sent eight reports.

Three Executive Board meetings were reported.

All reports were published entire in the State Journal.

Four reports were sent to the National Press and Publicity chairman.

The published reports, news clippings and programs were sent to Mrs. H. Miner for the State Scrapbook.

REPORT OF MEMBERSHIP ORGANIZATION COMMITTEE

Viola B. Hubbard, Chairman

The Membership and Organization Committee plans to send letters to the Medical Societies in those counties that have not organized an Auxiliary. In these letters we will inquire first as to why there is no Auxiliary in the county; second, as to those women in the county who would be likely to become interested in such an organization.

Follow up this letter with a personal or phone call and keep at it until something is started.

Call a conference of the organization chairmen in the counties that are already organized to plan a drive for new members.

Have the drive end at a certain date and award prizes for the county showing the best progress.

This committee would appreciate having presented to it any suggestions for improving the work for membership and organization in the state.

TIMELY TOPICS OF THE PUBLIC HEALTH COMMITTEE

By Mrs. Don A. Epler, Chairman of the State Committee on Public Health

The members of the State Auxiliary are interpreters to the public of the aims and functions of the medical profession, particularly with regard to preventive measures against disease. The County Auxiliary may take the opportunity to inject itself into every public health movement in its territory.

The peculiar opportunity of the Auxiliary is to approach the laymen and offer the services of the County Society in any movement promoted by a non-medical group. When a new health project is under consideration by a Parent-Teachers Association, for example, the doctor's wife may suggest a consultation with the county society representative in order to obtain the sanction and assistance of the medical profession.

It is entirely proper that the members of the Auxiliary should talk freely of the attitude of the Medical Society, when she would properly hesitate to advise a consultation with an individual doctor.

Vaccination and immunization through the "Public Health Hour" is an activity of physicians, important not only for the good of the society but

valuable to the members of the profession, in bringing them in contact with the people.

Under the present arrangements with the State Government providing the biologicals necessary, and with the boards of health and schools, leaving the pre-school children entirely in the hands of the family physicians, there is an incentive for immunizing the pre-school children, thereby keeping the physician in touch with the families and preventing the necessity for the State doing the immunizing later.

If the medical profession is to regain leadership in the health field, its leaders must clearly define the health needs of the present day. Such participation is to be centered in the physician's office, to offset the further development of free clinics.

Our duty as members of the Auxiliary is to assist our doctors in carrying out the details of the program set up by the County Society. By consulting our Advisory Board or Chairman of Public Health of our County Medical Society, we may be of assistance in promoting this work.

Atlantic County

Reported by Mrs. V. S. Mason

An Executive Board meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held on November 2nd, 1934.

Plans were discussed for a pre-Christmas card party to raise funds of the usual Christmas donations. Mrs. Carl Surran recommended that a prize for the best essay on health, and also for the most healthy boy and girl be offered in the eighth grades throughout the county.

Mrs. North, the President, announced that the President of The Medical Society had appointed Dr. E. H. Harvey, Dr. C. H. DeT. Shivers and Dr. C. Coulter Charlton to the Advisory Board of the Auxiliary. The suggestions sent out by Mrs. Casselman were read and discussed. The Board decided to concentrate its activities on a Speakers' Bureau.

A letter from the Pleasantville Red Cross asking for a donation was read.

The Chairman of Public Relations announced that she had secured two tentative dates for speakers.

The regular meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held at the Ambassador Hotel on Friday, November 9, 1934.

The recommendation of the Executive Board to give prizes for health essays was rejected.

It was decided to give a public card party early in December to raise the necessary funds for Christmas donations, the time and place to be decided by the entertainment Chairman, Mrs. David B. Allman, and her committee.

Two members of the Advisory Board conferred with the Auxiliary on establishing a speakers' bureau. They agreed to meet with their Chairman and arrange a list of topics and speakers.

Ten dollars was donated to the Pleasantville Red Cross and Visiting Nurses Association.

The new members who were present were welcomed and introduced by Mrs. North.

Following the business meeting, the members had a most interesting discussion of their various hobbies. There were sixteen members present.

Bergen County

Reported by Mrs. Charles Littwin

The regular meeting of the *Woman's Auxiliary to the Bergen County Medical Society* was held Tuesday evening, November 13th, at the Nurses' Home of the Hackensack Hospital.

Dr. G. M. Knowles, Secretary of the Bergen County Medical Society, described the set-up of the State and County Medical Societies.

Dr. H. B. Wilson, Chairman of the Medical Relief Committee of the Society, explained the work of the Medical Society in the Emergency Relief Administration, and told how his committee functions in checking the diagnoses of the physicians who have patients getting medical relief, and meeting monthly with Mrs. Henrietta Hawes, county E. R. A. director.

One of the most frequent problems, he said, is the prescribing of proprietary medicines by physi-

cians who do not realize that the E. R. A. will not approve such prescriptions.

Mrs. Beckner, the President, appointed Mrs. McCauly to act as chairman for a committee on philanthropic work.

Camden County

Reported by Mrs. Mildred B. West

The *Woman's Auxiliary to the Camden County Medical Society* held its Fall meeting on Tuesday, October 2, at the Camden Home for Friendless Children.

Mrs. Edward C. Pechin, the President, conducted a short business meeting. Mrs. Oram Kline was appointed to fill the unexpired term of Mrs. William Westcott, as Director, and Mrs. William Raughley was appointed Historian.

Dr. J. I. Holsopple, Chief Psychologist of the New Jersey State Hospital at Trenton, was the guest speaker. His topic was "Changing Attitudes Toward Children's Misbehavior". An invitation to hear Dr. Holsopple had been extended to all the Parent-Teacher Associations throughout the county.

After the address, which was thoroughly enjoyed by everyone, tea was served by the Hospitality Committee.

On Saturday, October 6, in the Junior Ballroom of the Walt Whitman Hotel in Camden, the *Woman's Auxiliary to the Camden County Medical Society*, held its annual card party for the benefit of the Camden County Tuberculosis Association. Mrs. Robert Gamon was general chairman for the party.

It was a very successful affair. A cake sale held in conjunction with it added quite a large sum to the proceeds.

Essex County

Reported by Mrs. Edgar II

A benefit Supper Dance sponsored by the *Woman's Auxiliary to the Essex County Medical Society* for the Benevolent Fund was held at the Essex County Country Club, attended by over 250 doctors and their wives.

The guests of honor included Dr. Edward J. Ill, Dr. and Mrs. L. Ely, Dr. and Mrs. F. J. Quigley, Dr. and Mrs. Leroy Wilkes and Dr. and Mrs. A. J. Casselman.

An Executive Meeting will be held at the Academy of Medicine November 26. Public Health Work will be outlined in coöperation with the Public Health Chairman of the Essex County Medical Society.

Arrangements will be completed for our Reel-prockly Meeting.

Plans are being made for a reception and tea for our new members on the fourth Monday in January.

Gloucester County

Reported by Mrs. Henry B. Diverty

The *Woman's Auxiliary to the Gloucester County Medical Society* held a benefit card party at the home of the President, Mrs. J. Harris Underwood, on Tuesday, October 23rd, at 2 p. m. Mrs. C. A. Bowersox, Mrs. B. A. Livengood and Mrs. I. J. Stewart were the committee on arrangements. The

spacious home was beautifully decorated in autumn garb. The Hallowe'en spirit was much in evidence.

Members and their friends made up the party. Thirteen tables were occupied, and other members moved about in a social way. All prizes were food—cakes, pies, candies, jellies, etc.

The main object of the party was to promote friendliness among its members. The proceeds will go into the treasury so that any incidental expense during the winter could be covered. Everyone seemed to do their utmost toward promoting sociability. The weather was ideal—a perfect hostess and home for the affair. Everything contributed to making the party a great success.

The Woman's Auxiliary to the Gloucester County Medical Society met at the Hotel Pitman on the evening of November 15th, and following a short business session joined their husbands in the dining room. Mrs. C. I. Ulmer and Mrs. T. M. Gardiner were hostesses.

Hudson County

Reported by Caroline Culver

The regular monthly meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held at the Y. W. C. A. building on the afternoon of Monday, November 5th, with the President, Mrs. Frank P. Nicholson in the chair.

The minutes of the previous meeting were read and approved.

The Treasurer and the Corresponding Secretary made reports.

The resignation of Mrs. F. Facciolo as Chairman of the Public Relations Committee was accepted, with regret. The President appointed Mrs. E. G. Waters to fill the place; it being in line with her work in connection with the Speakers' Bureau.

Mrs. B. T. D. Schwarz spoke in behalf of the Widows' and Orphans' Relief Fund; and it was moved, seconded, and carried that she send a round robin letter, to be enclosed with the notice of the December meeting, acquainting the members with the splendid work, and how we can all have a share in it.

Mrs. Howard Forman's resignation was accepted with regret, and one new member, Mrs. William Gleeson, was welcomed.

It was voted to continue the donation of five dollars to the elderly couple whom we are helping, until further notice.

Mrs. Charles Kelley, chairman of entertainment, spoke of the luncheon and card party to be given on Wednesday, December 5th, at the Barbizon-Plaza, New York, to help swell our fund for charity, and asked that we all support it. Reservations are to be made with Mrs. Henry Broeser.

The meeting was then turned over to Dr. John F. Von der Leith, the speaker, whose subject was "Germs and the Home". He gave an account of the development of bacteriological study and said that it is almost impossible to keep even the most carefully guarded home free from all germs. Hence, he recommended eternal vigilance and the use of preventive medicines. He also urged the women to inform themselves on the uses of different germi-

cides in order that they use the most effective kind for a particular case.

Tea and a social hour followed the talk, Mrs. Bernard Kelly, as chairman of hostesses, and her committee serving.

Mercer County

Mrs. Minerva W. Davenport, Secretary

A splendid luncheon was enjoyed by twenty-six ladies of the Woman's Auxiliary to the Mercer County Medical Society at the Y. W. C. A. on Monday, October 22nd, preceeding the first Fall meeting, which was called to order by the President, Mrs. Alton S. Fell.

The minutes of the Fall executive meeting were read and approved.

The Treasurer's report was accepted as read. The balance on hand October 22nd, 1934, was seventeen dollars and eighty-six cents (\$17.86).

A time was set aside for the payment of luncheon charges and dues.

The President then appointed chairmen for the following committees for the year:

Reception—Mrs. W. C. Ivins.

Flash (news items)—Mrs. Earle Miller.

Legislation—Mrs. J. J. McGuire.

Public Relations—Mrs. L. D. Haggerty.

Program—Mrs. LeRoy Wilkes.

Widows and Orphans—Mrs. A. S. Rogers.

Speakers' Bureau—Mrs. E. B. Beairsto.

Membership and Hygiene—Mrs. F. E. Proctor.

McKinley Hospital—Mrs. E. F. Purcell.

Mercer Hospital—Mrs. Chester Chianese.

St. Francis Hospital—Mrs. Paul Finnegan.

State Hospital—Mrs. R. G. Stone.

Plans for the year were outlined by the President, Mrs. Alton S. Fell.

A motion was made and seconded, the ladies of the Auxiliary would visit St. Francis Hospital Monday, November 19th, devoting the afternoon to making surgical dressings; each member to pay a small sum for luncheon.

It was suggested and approved by members present that a card party be held during February, the proceeds of which are to swell the much depleted treasury.

Mrs. Leo D. Haggerty, Chairman of the Public Relations Committee, reported arrangements were being made for a public relations meeting and tea to be held at the Contemporary Club. Invitations to be extended to outside friends and members of the Contemporary Club.

The Education Department of the Contemporary Club and Women's Auxiliary will act as hostesses for the afternoon. A short play will be presented and speakers engaged for the occasion.

Mrs. Earl Miller, Chairman of the Flash Committee, read a very interesting paper entitled "Medical Gleanings".

The Secretary read a report submitted by Mrs. Alvin S. Rogers, Chairman of the Widows and Orphans Committee, on the progress of her committee.

Dr. Robert P. Fischelis, President of the State Pharmaceutical Association and Secretary of the State Board of Pharmacy, delivered a splendid address on "Drug Control in New Jersey".

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OF

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January, 1934--December, 1934

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COMMITTEE ON PUBLICATION

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EDITORIAL OFFICE
137 EAST STATE STREET, TRENTON, N. J.

PLAN OF THE INDEX

This index to Volume XXXI of The Journal, that of the year 1934, is made up according to the departments of The Journal, as follows:

1. Original articles (scientific).
2. Authors of original articles.
3. Editorials.
4. State Society activities.
5. County Society activities and reports.
6. Woman's auxiliary.
7. Obituaries

OFFICIAL LIST

The Official List of Fellows, Officers, Delegates, and Members, was published as a supplement to The Journal of May, 1934.

OFFICERS AND COMMITTEEMEN

The Officers and Committeemen are listed on pages XX-XXII of the advertising section of each issue of The Journal.

ANNUAL MEETING MINUTES

The minutes of the annual meeting and the House of Delegates are contained in the OFFICIAL TRANSACTIONS, which was issued as a supplement to the August issue, with its own index on the first page.

ANNUAL REPORTS

The annual reports of the Officers and Committees were printed in The Journal of May, 1934, pages 255-294, with its own index on page 294.

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The *Journal of the Iowa State Medical Society* of June contains an editorial on a dispute between the College of Medicine of the State University and the practicing physicians. The causes of the dispute are listed as:

"First, it is contended that the College of Medicine is not serving in a full measure when its educational endeavors are limited solely to undergraduate medical instruction. The high standards of medical practice have their inception in undergraduate instruction, but are maintained only through diligent study extending throughout a lifetime.

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"The third fundamental cause for criticism of the College of Medicine by the practicing physician concerns the admission of private and semi-private patients to the State Hospital. Here the practicing physician feels that the faculty of the College, enjoying facilities furnished by state taxation and they themselves supported by adequate salaries, also derived by taxation, should not become competitors of their former students and other practitioners not favored by these opportunities.

"To eliminate all causes for dissension and discussion is to achieve a Utopia. To ignore these differences belittle their importance and defeats constructive planning. It appears, then, that these problems should be discussed by the members of the medical profession to the end that "the happiness of the people and the welfare of the state be advanced."

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THE TEXAS JOURNAL

Commenting on the cost of the Texas Journal, the Trustees of the State Medical Association, in their annual report in the June Journal, say:

"The Journal.—Necessarily, the *Journal* has remained restricted as to size. It has not, however, been in the least restricted as to cost otherwise. It has long been the policy of the Board of Trustees to spend on the Journal every cent it makes, and more. This is the one department that is permitted to run at a loss, and in excess of the budget—although, of course, even this privilege is closely supervised. Last year the Journal contained 1418 pages. Of these, the advertising pages numbered 530, considerably less than half, it will be noted. This year the closing volume, coincident in time with the fiscal year of the Association, numbered 1260 pages. Of these, 472 were advertising pages. The proportion of advertising to reading pages, it will be noted, is still smaller. This is

of importance when it is considered that one advertising page will support approximately two reading pages. The fifty-eight pages lost in the shuffle have been fairly distributed among the several departments, the transactions consuming the largest loss, from 62 to 40 pages.

"Last year this House of Delegates agreed to the policy of restricting the length of the published transactions of the annual session. Every word that was spoken in the House of Delegates or at the General Meetings last year, is of record in the office of the State Secretary, but the published version shows only a summary, perhaps, or the result of action. This is equally as informative as the publication of the extended remarks of each speaker would be, and the speaker's remarks in full are of record in the office of the State Secretary, available to all who may be interested and who have a right to know. We strongly recommend a continuation of this policy.

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CONTRACT PRACTICE IN TEXAS

The Committee on Economics of the State Medical Association of Texas made both a majority and a minority report. That of the minority, printed in the June Journal, says:

Contract Practice.—Contract practice is not objectionable when practiced according to the regulations prescribed by the Judicial Council of the American Medical Association, and we should follow these regulations until a better plan is offered. Rigid enforcement of the rules prohibiting competitive bidding and solicitation of contracts will eliminate the chief objection to contract practice.

Group Practice.—Of the many plans that have been suggested to eliminate the high cost of medical care and to provide adequate medical attention, group practice is the most practical and satisfactory one. In communities that offer ample hospital, medical and surgical facilities, low-salaried employees of large industrial concerns or groups of individuals, can organize themselves into associations and create a sufficient fund for the payment of adequate hospitalization, medical, and surgical services, for the per capita payment of a small monthly sum. This plan does not necessarily deprive the individual of the right of free selection of a physician, as each group may create its own medical organization.

Workmen's Compensation.—Millions of dollars are paid annually to the medical profession of Texas for the care of laborers, under the provision of the Workmen's Compensation Act, whereas a comparatively negligible amount was received for the same

service before this act was created. This law deserves the support of the medical profession. Insurance companies are being unjustly criticized in many instances because of decreasing remuneration of the physician for his services. It is true that our income from this source has decreased. This decrease is due partly to the demands of the companies for lower fees, as their premiums have declined, and is justified. Few of them have been unfair, and the chief blame for the decreased remuneration must be attributed to ourselves. Efforts of many to obtain compensation practice by underbidding and fee-cutting, in violation of our ethics, is the chief cause, and we should not blame the insurance companies for taking advantage of the practice. Competitive underbidding and solicitation have already cut the established fees as much as 50 per cent in some instances.

Conclusions.—As long as the State Medical Association limits its activities on medical economics to the routine reading and filing of the report of the Council, and allots its time to the reading of scientific papers and routine procedures of the House of Delegates, no progress will be made and we will bog deeper in the mire. Medical economics is of major importance, and our Association could profitably devote more time to its consideration. More interest would be created if one afternoon of each meeting were allotted to a general discussion of this subject.

No action was taken by the House of Delegates on this report.



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